EMS Care '86 Highlights

EMS Care '86—April 26 and 27—began on a quiet and reflective note as Ameen Ramzy, MD, state medical director of EMS field programs, spoke about Cpl. Gregory A. May and Tfc. Carey S. Poetzman. EMS Care '86 was dedicated to this Maryland State Police Med-Evac crew who were killed January 19 in a helicopter crash after transporting a patient.

Dr. Ramzy remembered Cpl. May and Tfc. Poetzman as good and decent people who each chose a dual role—that of law enforcement officer and EMS provider—and in that role, each valued life and tried to protect it. Both jobs involved risks.

Before presenting the families of Cpl. May and Tfc. Poetzman with plaques, Dr. Ramzy said that conference participants were offering the families a moment of recognition. He said: "We honor your loved ones today, not just because they are lost but because they gave so much while they were with us. We won't say to you that we know how you feel, because we can't. We want to honor you at this moment so that you know that we haven't forgotten, and we won't forget. We know that the sadness and the emptiness may never end but we share that with you."

Following the program dedication, R Adams Cowley, MD, director of MIEMSS, and William E. Clark, state director of EMS field operations, spoke on Maryland EMS today and the goals and changes anticipated for next year. The two-day conference, attended by 240 EMS providers, continued with lectures and workshops on such topics as infection, hypothermia, drug therapies, medical emergencies, EMT-defibrillation, sports injuries, prehospital quality assurance, and more. (Many of these workshops will be covered in future issues of this newsletter.)

The statewide finals for the EMS Olympics were held at the Montgomery County Public Services Training Academy on April 25, following the preconference programs. Five BLS and three ALS teams represented various regions in Maryland. Each team had 15 minutes to complete each of its two stations, and was evaluated according to preset criteria.

Winners were announced the following evening at the Mash Bash. Frederick County ALS and Laurel Volunteer Rescue Squad again captured first place in the ALS and BLS competitions, respectively. (They, along with several of the other winning teams, are pictured on pages 1 and 2.) In the BLS category, place awards included 2nd District Volunteer Rescue Squad (second place); Junior Fire Company (Frederick) (third place); Joppa-Magnolia Volunteer Fire Company (fourth place); and Flintstone Volunteer Fire Company (fifth place). In the ALS category, Rockville Volunteer Fire Company and Pleasant Valley Community Fire Company placed second and third, respectively.

The two first-place teams will represent Maryland in the national BLS and ALS competitions in the summer.

Those attending the Mash Bash saw Leon Hayes (member and former chairman of the Region V EMS Advisory Council) win the look-alike contest again this year as Corp. Klinger dressed as Carmen Miranda, famous for her "south-of-the-border" films.

—Beverly Sopp

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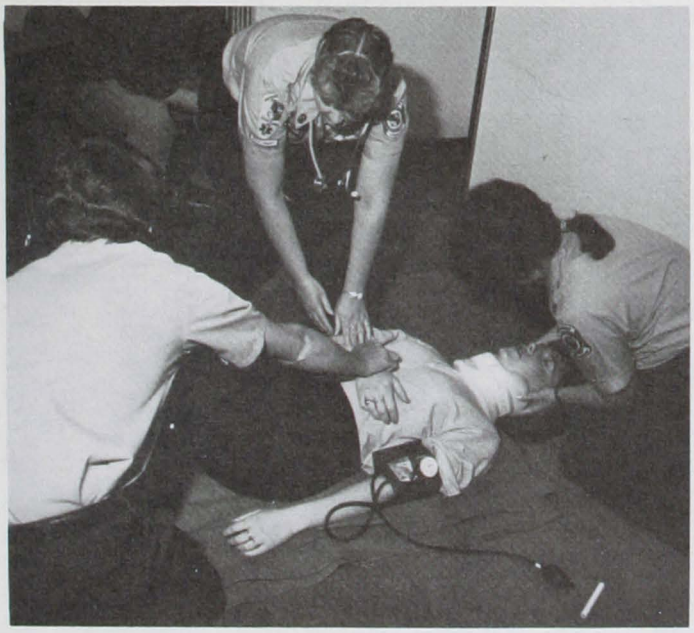

(L-r) Roland Berg, Laurie Carroll, and Deborah Fiedler from Laurel Volunteer Rescue Squad demonstrate patient skills. The team placed first in the BLS category.

(L-r) John Droneburg, Rick Himes, and Dwayne Danner from Frederick County ALS work to stabilize a patient. They placed first in the ALS category of the Maryland EMS Olympics.

1st Place, ALS . . . Chief M.H. (Jim) Estepp (Prince Georges County Fire Department) and William E. Clark (state EMS director) award a plaque to CRTs from Frederick County, Rick Himes and John Droneburg. Missing is Dwayne Danner.

2nd Place, ALS . . . (l-r) Keith Nachbar, John Capotosto, and Eric Rehbehn from Rockville Volunteer Fire Department with Chief Estepp and Mr. Clark.

3rd Place, ALS . . . Doreen Dutterer, Jim Korn, and Randy Stair from Pleasant Valley Community Fire Company were not at the awards ceremony.

1st Place, BLS . . . Laurel Volunteer Rescue Squad's team (l-r) Roland Berg, Laurie Carroll, and Deborah Fiedler, along with their coach Don Forrest, receive a plaque from Chief Estepp and Mr. Clark.

2nd Place, BLS . . . Members of the Calvert County's 2nd District Volunteer Rescue Squad, Lt. John Fonock and Lt. Lawrence Horsemen with Chief Estepp and Mr. Clark. Kenneth Carnes is missing.

3rd Place, BLS . . . Members of the Junior Fire Company (Frederick), Jill Keefer and Michael Angell with Chief Estepp and Mr. Clark. Todd Johnson is missing.

4th Place, BLS . . . Donna Compton and Ed Hammen from Joppa-Magnolia Volunteer Fire Company with Chief Estepp and Mr. Clark. Mel Wherman is missing.

5th Place, BLS . . . Mella Foster, Peter Macinta, R. Ken Shipway, and Michael Stotler from Flintstone Volunteer Fire Company were not at the awards ceremony.

Some Disasters Not Psychologically Damaging

A mental health center was severely damaged during the 1971 San Fernando earthquake. Just a few hours prior to the incident, a patient had been hospitalized, so hyperactive and uncontrollable that he had to be placed in restraints, a practice used only in extreme situations. When the earthquake struck, a nurse disengaged his restraints and told him that an 18-year-old catatonic girl could not get out of the building without his help. He escorted her to safety, remained coherent for a few hours, and then regressed to his disturbed condition.

The earthquake could be considered a situation of major stress. But most people, even clear-cut psychotics, reacted calmly, were other-oriented, and did not break down. This raises questions about the complex relationship between the pattern of disaster distress and mental health consequences. At the Stress and Behavioral Emergencies Conference at UMBC, the issues were explained by E.L. Quarantelli, PhD, professor of sociology and director of the Disaster Research Center at the University of Delaware, in Newark.

"It seems to be far more complicated than was previously recognized," says Dr. Quarantelli, who has personally researched over 450 major disasters. "We know more than we did 10 years ago, but in most instances we are still making educated guesses. The questions to ponder are, do disasters result in severe negative psychological consequences for the victims in the long and short run; what are the psychological effects of disasters; and are there consequences for people *other than* the victims, such as first responders and relief workers? There is no consensus yet. The answers are lean, but some evidence is starting to accumulate.

If stated in an unqualified way, according to Dr. Quarantelli, it can be said: "Disasters have not left in their wake masses of psychologically damaged victims. Survivors show very few signs of negative effects from their disaster experience." But if one can qualify, there are sharp differences between classes of disasters. Not between earthquakes and tornadoes, but between whether the disaster is a community-type disaster like a flood or tornado, or a non-community type, like an airplane crash. Dr. Quarantelli notes, "There are seldom severe psychological effects for the victims of community-type disasters, but there sometimes are for the victims of non-community types. It also depends on what you stress. If you stress psychological effects, yes, there are effects from all disasters. If you ask whether people are behaviorally dysfunctional, enough to impede their operation day-by-day, the answer is no."

Dr. Quarantelli emphasizes that finding psychological problems after a disaster is not evidence that the disaster was responsible for the problem. "On a normal, everyday basis, in any community in American society there are a number of adults who have varying degrees of psychological problems. The October 1984 National Institutes of Health study suggests that one-fifth of the adult American population suffers from one or more emotional disorders, ranging from disabling anxiety to schizophrenia. One could argue that if you go into an average American community after a disaster and find that 20 percent suffers from some kind of problem, you could say those people probably had those problems before the disaster occurred.

There have been 15 or 16 studies where an effort has been made to obtain systematic data on psychological well-being and mental health data. Among those are studies regarding the Buffalo Creek flood; the San Fernando earthquake; the 1974 Monticello tornado; the Mt. St. Helens volcanic eruption; the 1977 Omaha tornado; the Rapid City flash flood; the Rochester, Minnesota flood; the 1974 tornadoes and floods in the St. Louis area; the Teton Dam collapse; the Three Mile Island nuclear plant accident; the 1972 Topeka tornado; the Wichita Falls, Oklahoma torna-

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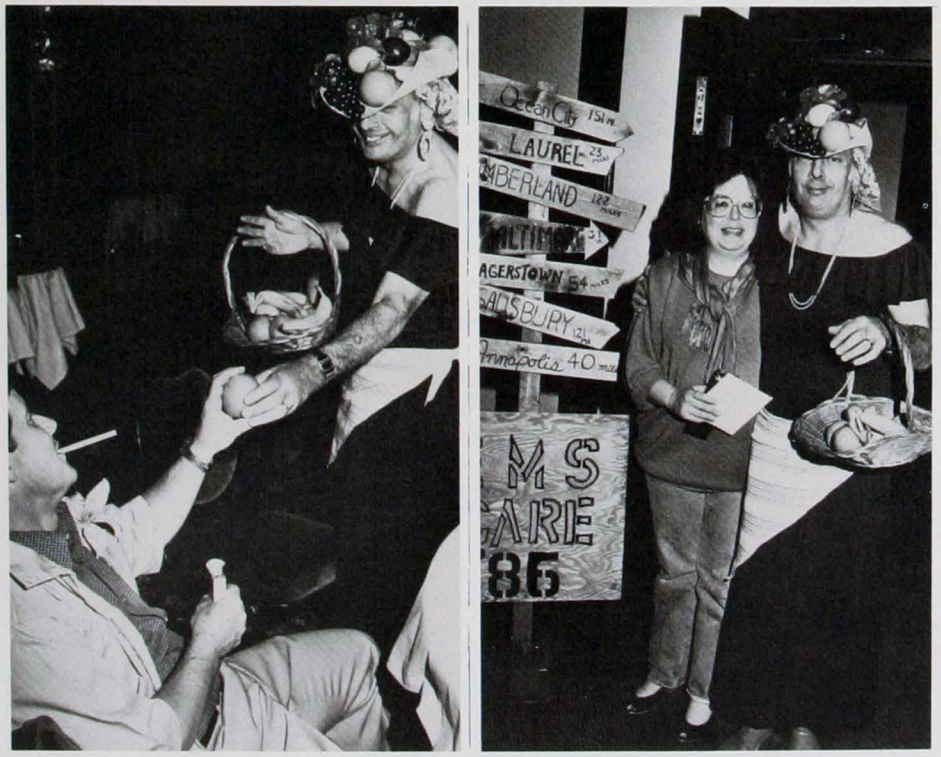
EMS Care '86



(Left) Leon Hayes (as Corp. Klinger dressed as Carmen Miranda) distributes fruit to Ron Schaefer and others at the Mash Bash. (Right) Marie Warner, Region V administrator and program planning coordinator for EMS Care '86, talks with Leon Hayes at the Mash Bash.

New REMSAC Officers

The new officers of the Regional Emergency Medical Services Advisory Council include: Kathleen Edwards, chairperson; William Barnard, vice-chairperson; and George Delaplaine, secretary.

ED Appraisal for Behavioral Emergencies

Editor's Note: The Emergency Department Evaluation is part 2 of a three-part series on the process by which it is determined whether a person should be committed to a psychiatric facility.

There are specific guidelines for the appropriate design of emergency facilities, particularly for psychiatric emergencies. Dennis Grote, MBA, associate director of the Greater Baltimore Medical Center and an EMT-IVT with the Rosedale Volunteer Fire Company, described what is necessary in an emergency department (ED) for the protection of patients and staff, at the Legal Aspects of Behavioral Emergencies Conference held at Sinai Hospital.

There should be an interior room not adjacent to a window, or with a protected window. There should be no sharp edges or glass present where psychiatric patients stay. Security should be available within a reasonable response time. (Ten minutes might be too long.) There should be a panic button available; you should not have to pick up the phone and *hope* someone comes. The room should be secluded, not accessible to unauthorized people walking through. Medications should be available 24 hours a day. And the area should be pleasant looking, not a cell. (The color of the room can affect patient-staff interaction. The color pink has been recommended.)

Humane restraints should be available, and everyone should know how to use them. Mr. Grote says, "We have a legal obligation not to use restraints beyond what is necessary, and not to inflict bodily harm." There should be an evacuation plan—what happens to the psychiatric patient if the fire alarm sounds? The room should have two doors, so staff cannot be boxed in. And it should not have a false ceiling; there have been instances of chasing people around a hospital through intersticial spaces.

Mr. Grote says there should be a well-defined plan for dealing with mentally disturbed patients, including a plan for commitment. It should be written, and integrated with recommendations of hearing examiners, public service agencies, and public protection agencies. According to Mr. Grote, "The institution should operate as though a psychiatric emergency is a routine situation." He says it is too late when the psychiatric emergency presents to the institution to try to decide what to do. These questions must be answered prior to the incident. "It is the administrator's responsibility to ensure that all members of the team—physicians, nurses, security, social workers, and psychiatrists—are together, recognize the team leader, know what to do, and have policies established so there are no questions when an emergency occurs."

Let us assume that an individual behaves erratically, leading a police officer to believe that he suffers from a mental disorder that makes him a danger to himself or others. The officer fills out a petition form and takes the disturbed person to the ED of a hospital for evaluation. If the disturbed individual is not violent, the role of the law enforcement officer now diminishes, and the staff of the ED takes over.

Most behavioral emergencies fit into one of two categories: either threatening violence or suicide, or being grossly disorganized. It must be ascertained whether the dysfunction is due to organic causes that impair the workings of the brain or to psychiatric causes. Within six hours of his arrival at the ED, the patient will be given a mental status exam. Cardinal symptoms of organic disorders like drug intoxication include fluctuating levels of consciousness, deficits of concentration, abnormal respiratory and heart rates, and difficulty in maintaining orientation. Paul McClelland, MD, director of the division of consultation-liaison psychiatry at the University of Maryland School of Medicine and director of the statewide Behavioral Emergencies Program, suggests that the first thing to be done in a mental status test is to make sure that the person is able to concentrate and is fully alert. "You can find out later that he has been shaking his head 'yes' without understanding the questions," he says. If a patient in the ED demonstrates some type of abnormal behavior or reports some type of pathological symptom, Dr. McClelland advises that the examiner give the patient a chance to explain why he behaved that way. There may be a logical explanation.

Just saying that the patient is having hallucinations does not help with triage. Hallucinations may be due to organic disorders as well as to psychiatric ones. There must be a more detailed explanation as to the type of hallucination. Olfactory hallucinations are generally organic in origin; what may be described as tactile hallucinations may be merely the person not being adept at verbalizing the sensation he is feeling. What seem to be auditory hallucinations might prove to be something as common as tinnitus.

Dr. McClelland suggests that psychiatric and neurological exams should be done together. "If there is a question of weakness on the right side of the patient's body the mental status exam might reveal an aphasia or another disturbance which is associated with dysfunction of the left side of the brain (as is weakness on the right side).

There are checks and safeguards to protect a person from being committed involuntarily. The criteria for commitment are the presence of a mental disorder; a need for inpatient care or treatment; the patient must present a danger to the life or safety of himself or others (destroying property is not sufficient reason); the individual must be unwilling or unable to be admitted voluntarily; and there must be no less restrictive forms of intervention consistent with the individual's welfare and safety.

There are frustrations in the management of a patient with disturbed behavior in an already busy ED. Some of the frustrations come from dealing with outside agencies, each with its own rules and regulations. Kathleen Yanks, MS, RN, behavioral emergencies nurse consultant at Frederick Memorial Hospital, explains: "Every ED nurse knows that when a patient with a serious psychiatric problem comes in it may take from 6 to 12 hours or more to assess, place, and arrange transport for that patient for whom psychiatric hospitalization is required. In the meantime, the patient may become more restless and disturbed, requiring more help. The ED staff is often depleted by the attention required for such patients."

Nurses sometimes feel that with the "appropriate" care plan one should be able to alleviate the patient's symptoms. Ms. Yanks says, "It is most useful for the nurse to remain in a neutral position . . . if not, both the nurse and the patient

(Continued on page 5)

Disasters Not Always Bad Psychologically

(Continued from page 3)

do; and the Xenia, Ohio tornado. These range from metropolitan areas to little hamlets all around the country, and were subjected to a variety of disaster agents.

Research is hampered by the lack of predisaster data. There is no proof that problems result from disasters, because there would have to be scientific evidence to show that they were not attributable to predisaster times. One of the very few studies that had controlled data was in Topeka, Kansas, where the Menninger Foundation is located. For years they had been studying people in the neighborhoods of Topeka. When the tornado went through there were solid preimpact data on the people with which to contrast the postimpact data. When they matched pre- and post-tornado families, marriages were rated happier than before, happier than in non-victim families. Very little showed up in the way of psychological difficulties, and no more among victim than non-victim families.

An extensive field study was conducted after the Xenia, Ohio tornado, first at 6 months, and again at 18 months after impact. (The people surveyed in the second sampling included those in the first, in order to have longitudinal data.) Eighteen months after the disaster, there was an extremely low rate of severe mental illness. On the contrary, a large percentage of people had positive reactions to the disaster: 84 percent claimed that their experience showed they could handle a crisis better than they had expected; 69 percent felt that they had met a great challenge and were better for it. Only 2 percent related worsening of relationships with family or close friends; 27 percent claimed to have closer relationships; 3 percent found their marital relationships less satisfying; and 28 percent found more satisfaction in their marriages afterward.

Only 3 percent reported feeling that they might have nervous breakdowns; 1 percent considered suicide; 3 percent reported an increase in drinking; and 17 percent were trying to consume less alcohol. There was a slight decrease (from 20 to 16 percent) of the population using tranquilizers; and the use of the services of mental health agencies declined from 10 to 5 percent. "Behavioral indicators supported what the victims had self-reported," Dr. Quarantelli states. After the Three Mile Island accident, the most studied event of its kind, it was also concluded that "such events as surfaced were of the subclinical kind, short-lived. There are no scientific data to support the belief that the accident caused medical or gross psychological problems." This study and others do not claim that there are no psychological effects of a disaster. People report feeling depressed or low on occasion, nervous, having sleeping problems, headaches, and some loss of appetite.

Dr. Quarantelli explains, "While a few researchers see mental health effects of disasters as widespread, deep, persistent, long-lasting, and dysfunctional, the majority of researchers appear to agree that much of the reaction is surface, non-persistent, of short duration, and not behaviorally dysfunctional. They further argue that it is possible that community disasters generate significant positive psychological effects in the long run. We must qualify this by pointing out that primarily we are talking about certain kinds of disasters. Extreme situations such as the Holocaust, shipwrecks, air raids, famine, mass kidnappings, plane crashes, concentration camps, or military combat may be classified as disasters, but are not among those under consideration in this discussion."

—Erna Segal

ED Appraisal: Behavioral Crisis

(Continued from page 4)

might be headed for frustration. It is almost impossible to find a simple, logical solution to a tremendously complex problem about which little is known. We must be aware that the key to understanding the problems of behavioral emergencies in nonpsychiatric settings —and therefore the key to managing them better—is ongoing, inservice education."

The law requires that prior to commitment a person must be examined and have certificates signed by two physicians or a physician and a psychologist, and one of them must write a note describing the findings of the examination in enough detail to warrant commitment. There is often misunderstanding on this point. Elizabeth Eckhardt, an attorney and hearing examiner appointed by the state, says: "Sometimes we find that a patient has been examined only by one doctor who sent the nurse down the hall to find another doctor to sign a second certificate without seeing the patient.

"By that action, the individual's rights have been violated. Many times we release a patient based upon such a technicality, and we're not any happier about it than you are. Invariably, the patient who manages to obtain a technical release is the one still swinging from the chandelier. *But if the law has been violated, we have to let him out."*

Ms. Eckhardt says that the more descriptive evidence the ED sends in, the better it is. Sometimes a hospital will try to include the patient's history, but it may be too old to be admissible as evidence. It is better, if a family member is present in the ED, to have him tell as much as possible about what was going on at home that caused the patient to be brought in. *Have this included in the physician's note.*

It is insufficient for the physician to write, "Has mental disorder. Needs inpatient care. Is dangerous." This is not valid, Ms. Eckhardt emphasizes. "You might as well save the paper. We are looking for facts—if you say he is depressed, tell us what makes you think so. Tell us what actions of his you think are dangerous. If a patient is dangerous because he won't take his medicine, the physician's note should read, 'The patient's pattern is ———. He goes off his medication after ——— weeks. In January, because of his failure to take his medication, he did thus-and-so.' It's the facts that will keep him in the hospital."

When the patient leaves the ED, there should be medical records to document his treatment, and a quality assurance program to ask whether adequate treatment was provided in a timely fashion. There should be a critique after each incident to determine whether it went well. "The object is to make sure that the next time we will do things better. We are dealing with human beings; we do not rest on our laurels," Mr. Grote says.

—Erna Segal

EMS Legislation 1986 . . . Legislation . . .

The 1986 General Assembly passed several bills that are of interest to EMS providers. Among them are mandatory seat belt usage; additional funding for the new MIEMSS Shock Trauma Center; notification to prehospital providers about infectious diseases to which they have been exposed by patients that they have transported; a requirement for emergency department staff to report serious burn injuries; and scholarships for public safety personnel and their children.

Below is a summary of some of the EMS-related bills that passed in this legislative session.

SB 15 (HB 110) Mandatory Seat Belt Usage. Front seat occupants adjacent to a door of a Class A (passenger) or Class M (multipurpose) vehicle, including children less than 16 years of age, must be restrained by seat belts as of July 1. This may be enforced only as a secondary action when a police officer detains a driver for suspected violation of another code. It is not considered a moving violation, and no points are given. The driver may be fined. Exemptions are possible if a physician certifies in writing that due to a medical problem or physical disability wearing a seat belt would be inappropriate.

SB 338 Creation of a State Debt—Maryland Institute for Emergency Medical Services Systems. Authorizes the creation of a $7 million State Debt to be used as a grant to the University of Maryland Medical System Corporation for MIEMSS for the design, construction, renovation, and equipping of emergency medical and support facilities. (This is part of the additional $10 million promised to the Shock Trauma Center last year. The remainder will be proposed by next year's legislature.)

SB 428 Concerning Physicians Reporting Burn Treatment. Requires that physicians or registered nurses who treat individuals for burn injuries (not to include sunburn) causing second- or third-degree burns to 5 percent or more of the body; to the upper respiratory tract, or laryngeal edema caused by inhaling super-heated air; that cause death or that are likely to cause death must notify the county fire chief or administrator. Persons who do not give the required notice are liable for a civil penalty of not more than $100. This information will assist in the collection of burn injury data not available from present records.

SB 527 Fire Prevention Commission. Requires the State Fire Prevention Commission to promote and conduct at least once each year seminars, conferences, workshops, and meetings to inform the public and fire fighting personnel of the latest techniques in fire prevention programs and procedures; life safety measures; changes in the state fire prevention code; and development of improved fire safety goals.

SB 582 (HB 1013) Exposure to Infectious Diseases—Notification and Benefits for Fire Fighters and Emergency Medical Technicians (EMTs). If while treating or transporting an ill or injured patient to a medical care facility, a paid or volunteer fire fighter or EMT comes into contact with a patient who is subsequently diagnosed as having an infectious disease, the attending physician or physician's designee who receives the patient shall notify the fire fighter or EMT and his employer of the individual's exposure to the patient. Notification shall be made within 48 hours; shall include written protocols for the appropriate treatment or medical surveillance; and shall be conducted in a manner that will protect the confidentiality of the patient and the fire fighter or EMT. Some of the infectious diseases that must be reported include: gonococcal infections, hepatitis, meningitis, post-exposure rabies treatment, staphylococcal and other infections, syphylis, tuberculosis, and Group A beta-hemolytic streptococcal infections. The bill also provides for disability benefits for the fire fighter or EMT who is unable to perform active duties and for death benefits for the survivors of one who dies due to an infectious disease to which he was exposed while in active service.

SB 711 (HB 1380) Guidelines Governing the Transfer of Patients Between Hospitals. These require: 1) Notification to the receiving hospital before the transfer, and confirmation that the patient meets that hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to the patient; 2) the use of medically appropriate life-support measures that a reasonable and prudent physician would use to stabilize the patient before and during transport; 3) the provision of appropriate personnel and equipment for the transfer; and 4) the transfer of all necessary records for the continuing care of the patient. A penalty of $1,000 may be imposed per violation.

SB 745 (HB 746) Autopsies on Fire Fighters. This repeals certain contingencies that have impeded the effectiveness of Chapter 246, Acts of the General Assembly of 1984, allowing the bill to become effective as of July 1, 1985.

HB 757 Chemical Test for Alcohol-Refusal—Admissibility. This bill provides that evidence of refusal to submit to a chemical test for alcohol is admissible at a trial for violation of certain motor vehicle laws.

HB 767 Scholarships for Public Safety Personnel and Their Children. Children of public safety personnel who were disabled or killed in the line of duty may qualify for tuition assistance. Also, any career or volunteer fire fighter, ambulance, or rescue squad member actively engaged in these activities in this state shall receive full and complete reimbursement for tuition costs not to exceed resident tuition rates at the University of Maryland College Park for courses toward a degree in fire service technology or emergency medical technology.

HB 793 Exempting Anne Arundel County from Federal Government Reimbursements. Anne Arundel County will be exempt from reimbursement from the federal government for the provision of fire fighting or rescue activities on federal property. Other jurisdictions may enter into different agreements with the federal government; individuals who sustain injury while engaged in such activities shall be entitled to benefits.

HB 845 Hospitals—Patient Care Advisory Committees. High-technology tools of medicine that prolong and save lives frequently put families in a position where they need experts to consult regarding the initiation and/or continuation of treatment. This bill provides a mechanism to aid the family in confronting difficult decisions. Each hospital will establish, if it does not already have, committees to render advice to patients' families. The committees shall include but not be limited to a physician not

(Continued on page 7)

Legislation . . . Legislation . . . Legislation

(Continued from page 6)
directly involved with the care of the patient in question, a registered nurse, a social worker, the hospital's chief executive officer or designee, and other individuals appointed by the hospital.

HB 912 Creation of a State Debt—Southern Maryland Med-Evac System. Incurs indebtedness of $850,000 to be paid to the Maryland State Police to provide med-evac and aerial law enforcement services for southern Maryland through the acquisition of a helicopter; the planning, design, construction, and equipping of hangar facilities; and the acquisition of patrol vehicles.

HB 1027 Hospitals—Request for Consent for Anatomical Donations. It will become routine for nonemergency hospital admissions for hospital personnel to 1) ascertain whether the patient is currently an organ or tissue donor; and 2) include the information on the patient's admission form. Also, when an individual dies in a hospital, the hospital administrator or designee shall request, with sensitivity, that the patient's representative consent to the donation of all or any of the decedent's organs or tissues as an anatomical donation if suitable.

HB 1340 Carroll County—State Fire, Rescue, and Ambulance Fund. For Carroll County only, the definition of "expenditures for fire protection" or "expend for fire protection" means county revenues appropriated shall be used to finance facilities that house fire protection apparatus and equipment. It excludes salaries, workmen's compensation, fringe benefits, or other personnel, except training or administrative costs. It does not include loans to a volunteer fire, rescue, or ambulance company, secured by mortgages, notes, or other evidence of indebtedness if the appropriations derive from the proceeds of bonds to finance facilities that house fire protection apparatus and equipment.

HB 1428 State Fire, Rescue, and Ambulance Fund. This bill prohibits the Secretary of Public Safety and Correctional Services from adopting certain procedures relating to capital equipment when implementing the fund. Some of its provisions are that the Secretary may not (except as otherwise provided) impose training or operational requirements as a precondition to receipt of funds or require that capital equipment purchased with state funds have a useful life expectancy of greater than one year. State funds provided under this section may be used for acquisition or rehabilitation of fire or rescue apparatus, including ambulances; capital equipment used in connection with fire or rescue apparatus; and rehabilitation of facilities used primarily to house fire fighting apparatus, equipment, ambulances, and rescue vehicles. State funds provided under this section may *not* be used for: administrative costs; compensation or fringe benefits; travel or meal expenses; fuel, utility, or routine maintenance costs; acquisition of new or replacement fire hydrants, water mains, or emergency alarm systems not installed at a fire, rescue, or ambulance facility; insurance, fund-raising activities; refinancing of any debt incurred before July 1, 1985; replacement or repair of eligible items to the extent that insurance proceeds are available; costs associated with the 911 system; or land acquisition.

HB 1466 Emergency Preparedness Plan. This bill was changed from its initial form, which focused on occupational safety and health and disaster prevention. It now requires each county and Baltimore City to prepare a plan for responding to an emergency involving hazardous materials or controlled hazardous substances. Each jurisdiction must submit its plan to the Secretary of Public Safety and Correctional Services by July 1, 1987.

Several bills of interest to EMS providers did not pass during this legislative session. These include the mandatory use of motorcycle helmets, seat belts on school buses, and restitution of expenses for emergency responses for alcohol- or drug-related driving offenses.

Another bill that did not pass still holds great promise for the future. *SB 970, the Emergency Services Fund,* became commonly known as the "$3 Bill." In the wake of the tragic Med-Evac helicopter accident that killed two Maryland State Police crew members it became apparent that it was necessary to upgrade the emergency transport system. It was proposed that adding $3 to the motor vehicle registration fee would be a just way of raising monies to upgrade the system, since motor vehicles are involved in the majority of EMS cases. Problems that must be ironed out include financing, administration, and how to adapt it to the new three-year rotation system in registration. It is hoped that the bill will be introduced into next year's legislation after review by a consultant committee.

—Erna Segal

Region I

The Western Maryland Trauma Disaster Shortcourse, held May 3 and 4, attracted over 180 EMTs and CRTs from four states. Cosponsored by Garrett Community College, the Maryland Fire and Rescue Institute, and MIEMSS, the shortcourse concentrated on pediatric trauma care, with instructional leadership provided by the Children's Hospital National Medical Center in Washington. Region I thanks the Children's Hospital staff and all the EMTs and CRTs who made the program a success.

—Dave Ramsey

Chopper Regs Promote Safety

Statewide helicopter regulations went into effect in Maryland for the first time in March 1986 to enhance helicopter safety and to improve communication between helicopters and hospitals.

An amendment passed by the 1984 Maryland General Assembly authorized the director of MIEMSS to promulgate these regulations. They were drafted with existing historic Maryland State Police (MSP) protocols in mind and meet with MSP approval.

The regulations promote helicopter safety by giving guidelines to all helicopters, whether local, out-of-state, or military, for communicating with area-wide trauma centers and specialty referral centers throughout the state. Through the use of central alarms, the MIEMSS Systems Communication Center (SYSCOM) acts as the focal communications point to inform trauma centers about the estimated time of helicopter arrival and whether the patient might have special needs. It also monitors traffic to ensure that helicopters do not converge on the same space and notifies pilots if helicopters are nearby.

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Field Notes

By William E. Clark, State EMS Director

EMS response to mass casualties resulting from either natural or man-made catastrophies is a reality that any of us could face at any time.

It now seems that a month hardly goes by without a major incident or disaster being reported around the world. Certainly the increasing incidence of terrorism raises an entire new specter of targets that requires all EMS systems to reevaluate their disaster response plans.

In the United States we are fortunate to have an emerging new approach to combining federal and nonfederal medical resources into a unified response for major disasters. The National Disaster Medical System (NDMS) is a partnership of private and public sectors that creates nothing new. What it does is network together available resources into a viable system.

We, in the northern Virginia, District of Columbia, and Maryland area, are strong supporters of NDMS, and we demonstrated our active support at a major mass casualty exercise in September 1985 where 600 casualties were received at Andrews Air Force Base and BWI Airport and were transported to the NDMS participating hospitals in the region.

This year, on July 26, a much more ambitious exercise is going to be conducted. Called NDMS-86, the scenario calls for 1,000 casualties resulting from a mock disaster at the Capital Center.

On-scene command will be provided by the Prince Georges County Fire Department and casualties will be turned into patients through a systems approach to mass casualty care.

It is anticipated that several hundred casualties will actually be flown out to other areas of the country to receive care.

As they did last year, many organizations and individuals will be participating in the exercise. Anyone wishing to volunteer to support the exercise can contact any of our regional EMS administrators or me for further information.

Together we can play an important role in helping to operationalize the NDMS and to be better prepared to deal with the medical care requirements of a disaster of great magnitude.

Region III

We would like to welcome Capt. Joseph Sontagg to the Baltimore County EMS office. One of the first CRT and EMT instructors, he will replace Capt. Reggie Shephard who is transferring to the fire suppression side of the department. We thank Capt. Shephard for his dedication and work over the past years, and wish both Reggie and Joe good luck in their new positions.

In July, Roman Goy, MD, and Michael Stang, MD, will become the new emergency department directors of Fallston General Hospital and Carroll County General Hospital, respectively. Dr. Goy has been involved in Maryland EMS since 1978, first at Johns Hopkins and more recently at Francis Scott Key Medical Center. Dr. Stang worked in Franklin Square's emergency department and has made several contributions to Maryland EMS. We look forward to working with both physicians.

—John Donohue
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