Maryland EMS NEWS
Vol. 11 No. 12 JUNE 1985

(Top) Rescue workers treat one of the victims of an accident on the Route 50 Bridge over the Severn River. (Below) Occupants of the crushed, smoldering Audi were flown to the Baltimore Regional Burn Center, while the driver of the tractor-trailer who caused the accident was flown to the Shock Trauma Center. (Photos by Keith Harvey courtesy of "The Annapolis Capital.")

Truck, Auto Crash in AA Co.: Rescue Teamwork

Switching lanes, the tractor-trailer hooked bumpers with an Audi 4000. The Audi spun to the left, was hit by the truck broadside, and was pushed into the center guardrail, where it exploded. The truck caught fire, veered across the roadway, and struck the outer guardrail. It knocked a 20-foot section of railing and a piece of concrete from the bridge into the water, before it came to a stop about 100 feet away. The rescue of the victims of this accident on the Route 50 bridge over the Severn River near Annapolis in Anne Arundel County, on March 27, brought Maryland's coordinated EMS system together in a multi-faceted effort that included fire engines, paramedic units, BLS ambulances, helicopters, and boats, along with state, county, city, and marine police.

The crash was reported by CB radio from a car at the scene. Paramedic 17, a unit from Arnold, with two firefighters/CRTs, William Cooper and John Greene, was the first to respond. With total disregard for their own safety, CRTs Cooper and Greene made their way past burning fuel covering the bridge to rescue the driver of the truck and the two occupants of the car. They have been recommended for awards for their heroic actions.

Heat from the burning truck was so intense that the cab disintegrated, and the trailer connection wheel melted and fused to the trailer. According to V. Richard Molloy, public information officer for the Anne Arundel County Police Department, the truck would have driven over the edge of the bridge, but the front axle broke off, allowing the rear axle to catch on the curb. The trailer was relatively undamaged, but the auto was demolished. "It looked inconceivable that anyone could come out of that car alive," Officer Molloy states.

Division Chief Roger Simonds, who is in charge of emergency medical services for the Anne Arundel County Fire Department, received the call at headquarters in Millersville. Chief Simonds, as officer in charge of the emergency medical and rescue operation, worked with paramedic units, engine companies, volunteer rescue companies, the Third Battalion chief, and the shift EMS officer. Units involved were Engine 17, from Arnold; Engine and Truck Company #23 from Jones Station; Engines 401 and 402 from West Annapolis; and Engine 46, from the U.S. Naval Academy.

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Rescue Teamwork Credit to MD EMS

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Other medical units responding were Ambulance #19, from Cape St. Claire; Ambulance #3 from Riva; and ALS units #12 from Earleigh Heights and #39 from the city of Annapolis. There were unconfirmed reports that a vehicle had fallen into the water where the railing was missing, so a boat from the Natural Resources Police (formerly known as the Maryland Marine Police) from the city dock in Annapolis, along with a utility boat and a small boat from Station 2, Woodland Beach, responded and searched the debris in the water.

The truck driver, the driver of the car, and his passenger were all seriously injured. The trucker suffered blunt multiple trauma and second-degree burns to his hands and face. He was flown by U.S. Park Police helicopter to the MIEMSS Shock Trauma Center, where he was hospitalized for about a month until his discharge in April. Charges are pending against him.

The automobile driver had burns over 5 percent of his body, but his passenger was more seriously injured. Pushed out of the burning car by the driver, the passenger had flames engulfing his body. Although a passing truck driver grabbed a blanket from his cab and rolled him in it to extinguish the flames, the passenger still suffered burns over 76 percent of his body. The automobile driver and passenger were flown to the Baltimore Regional Burn Center at Francis Scott Key Medical Center by a Maryland State Police Med-Evac helicopter making two trips. The driver was released after treatment on the same day. The passenger died a week later of his burns and smoke inhalation.

Chief Simonds observes that contingencies had been made to manage a situation of this magnitude on a daily basis, making it unnecessary to put a disaster plan into operation. "Our levels of response work effectively," Chief Simonds states. "If there is any question, we err in favor of the patient, and add the next level of response. This operation was a success due to the cooperation of multiple agencies involving both career and volunteer units, and was readily managed because the personnel were well trained. Everyone worked in a creditable and professional manner. It was a job well done."

—Erna Segal

Legislation Affecting EMS

Many bills that were passed by the 1985 General Assembly will impact directly on the Maryland EMS system.

Local fire and ambulance companies will receive state aid; money was provided for upgrading the statewide EMS communications system; and funding was provided for the start of a new Shock Trauma Center building. Health care cost containment legislation did not end up in the potent form in which it was introduced. There were a number of exclusions, exceptions, and changes to the legislation, but steps were taken to put a cap on the increase in health care costs.

State EMS Director at MIEMSS, William E. Clark is "extremely pleased with the legislation enacted this year by the General Assembly and signed into law by Governor Harry Hughes because it will enchance our EMS System capabilities at the local, regional, and state levels. We are fortunate that we have elected officials who continue to strongly support our mutual efforts in providing the 'Best Care Anywhere.' We at MIEMSS sincerely appreciate everyone's efforts."

Below are some of the bills that were passed by the legislature.

Senate Bills

SB 164: Maryland State Fireman's Association—Appropriation and Use of Funds. This bill will expand the type of fire prevention information the MSFA can publish and distribute.

SB 298: Health Insurance—Preferred Provider Policies or Preferred Provider Contracts. Permits the offering and administration of preferred provider health insurance policies or insurance contracts. It also provides for terms and conditions of these policies or contracts.

SB 343: Freestanding Medical Facilities—Emergency Medical Care. This bill requires the Department of Health and Mental Hygiene to adopt regulations for certifying freestanding medical facilities which use the words "urgent" or "emergency" or other words indicating the ability to provide treatment to patients with life-threatening injuries or serious illnesses. It requires a facility to be certified based on specific requirements and standards before it goes into operation.

SB 492: Health Care Cost Containment—Licensing Major Medical Equipment. Requires a license to be issued to health care providers before they may lease, acquire, or use major pieces of medical equipment costing $600,000 or more. The bill exempts the purchase of major items of equipment from the Certificate of Need (CON) process.

SB 494: Health Care Cost Containment—Moratorium—CON. This bill places a moratorium on all CON applications from February 1 through October 1, 1985. There are, however, exceptions to the moratorium that will permit certain CONs to be considered.

SB 495: Health Care Cost Containment—Health Resources Planning Commission. This bill authorizes the Health Resources Planning Commission to impose certain penalties for failure to provide requested information. It also authorizes the commission to study the CON process and recommend changes, and to send certain information to local health planning agencies.

SB 508: Public Safety—Fire, Rescue, and Ambulance Services. This bill establishes a new state aid program for fire protection, rescue, and ambulance services of the state. It creates a State Fire, Rescue, and Ambulance Fund to be funded by appropriation, and establishes a distribution formula to counties. It establishes certain requirements as a condition of receiving funding, and specifies the purposes for which the money is to be used (acquisition or rehabilitation of fire or rescue apparatus, including ambulances; acquisition or rehabilitation of capital equipment used in connection with fire or rescue apparatus; and rehabilitation of facilities used primarily to house firefighting apparatus, equipment, ambulances, and rescue vehicles).

SB 655: Health Care Cost Containment—Hospital Mergers and Consolidations. Mergers and consolidations of health care facilities are encouraged through this bill. The bill requires the Planning Commission to develop and adopt an institution-specific plan and to incorporate it into the state health plan. It exempts from the CON process certain expenditures necessary for merger or consolidation, and provides for the retraining and placement of dislocated hospital employees. It also creates a joint committee on health care cost containment.

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Sheriff's Deputies Help Volunteer EMS

Sheriff's Deputy/CRT (back to photograph) prepares medications to be administered to the cardiac arrest victim while rescue personnel perform CPR. The deputy was dispatched to the auto accident as a CRT at the request of the responding fire/rescue company. (Photo courtesy of Cecil County Sheriff's Department.)

In Region IV, several rural counties dependent on volunteer manpower for prehospital care have discovered that sometimes an employer will not allow a volunteer to leave his job, or other obligations prevent him from responding to an EMS call. At times an ambulance company cannot respond because a crew is not available, and ALS is delayed or absent.

Cecil County EMS providers are making an effort to resolve this problem through a cooperative system of tiered response that combines volunteer fire/rescue companies and the Cecil County Sheriff's Department. Traditionally, the role of the sheriff's deputy has been restricted to patrol activities, that is, criminal/traffic investigation and service of civil process. The deputies traveling throughout their jurisdictions were a potential link to the county's rural EMS system.

Recognizing this valuable link, the Cecil County Sheriff's Department and the Singerly Fire Department of Elkton developed a program that would utilize law enforcement officers trained in emergency medicine. The Singerly Fire Department is a volunteer EMS organization.

Several members of the Sheriff's Department patrol division were members of local fire departments and were certified as EMTs or CRTs. Knowing this, the Singerly Fire Department ambulance staff asked that Sheriff John F. DeWitt permit these men to be dispatched to an emergency medical incident when their service was requested. Sheriff DeWitt complied by ordering the development of the Deputy EMT/CRT program, which allows those uniformed deputies trained as EMTs or CRTs to be dispatched upon request from the county fire headquarters to a medical emergency.

In 1982, in response to Sheriff DeWitt's request, Deputy First Class Frank W. Muller organized the pilot program in which medical guidelines and protocols established by MIEMSS were adopted. Deputy Muller, a CRT who has instructed many of the CRTs in the county, with another deputy CRT and a deputy EMT, served in an advisory capacity to set up the program. There are now two CRTs, one EMT in a CRT course, and two taking the EMT course.

A deputy on duty responds as an EMT/CRT only if the responding ambulance company requests his assistance. It is vitally important that the volunteer prehospital care provider does not feel that a "paid" person is doing his traditional job; therefore, all law enforcement personnel participating in the program are members of the volunteer companies as well.

Many times the deputy arrives at the scene of the medical emergency prior to the ambulance because he has been dispatched while on patrol in that vicinity. According to Deputy Muller, it is possible to decrease response time by six to nine minutes, if the deputy can provide care until the ambulance arrives. He performs BLS and EMT-Intermediate levels of intervention. The EMT/CRT patrol units are equipped with emergency medical supplies and equipment, ranging from oxygen therapy equipment to IVs. These units are assigned to the deputies for both on- and off-duty use.

When the ambulance arrives, the deputy relays patient information and status to the crew. If the ambulance is staffed by a CRT, the patient care is turned over to that member. If personnel on the ambulance have lesser levels of training, the deputy accompanies the patient on the ambulance to the receiving medical facility, after securing his vehicle at the scene. He is returned to his patrol unit later by another deputy or the ambulance crew.

Although not a part of the Deputy EMT/CRT program, 20 patrol division members and several members of the detention division staff have been trained as first responders, through the Crash Injury Management Program. The department encourages its members to enroll in EMT training courses when available, but persons involved or certified in the Deputy EMT/CRT program do not receive any extra monetary compensation for this specialization. The Sheriff's Department also actively participates in CPR training programs for the public, in cooperation with other organized EMS providers in the county.

Since the program's inception, it has been utilized by most of the Cecil County ALS companies. The number of requests have increased, and the Sheriff's Department has found no reduction in basic police services normally performed by the Deputy EMTs/CRTs. It is planned to expand the number of personnel in the program.

— Erna Segal

Children's Deaths from Injury Preventable

"If one compares injuries with cancer, which is the second leading cause of death in children ages one to four, injuries kill roughly six times as many children as cancer. In children above age five, injuries rapidly surpass all diseases combined as a cause of death," explains Susan P. Baker, MPH, professor of health policy and management at the Johns Hopkins School of Hygiene and Public Health. Mrs. Baker is co-director, with J. Alex Haller, MD, professor of pediatric surgery and pediatric surgeon-in-chief at Johns Hopkins Hospital, of a program funded by a grant from the Robert Wood Johnson Foundation for the study and control of childhood injuries. Mrs. Baker's part of the study, with the goal of developing preventive strategies and trying to implement them, was described at the Seventh National Trauma Symposium last year.

It is difficult to obtain necessary data from ambulance or trauma center records, because children may be brought to hospitals by private cars, taxis, ambulances, or helicopters. The cases of more than 1,000 hospitalized children in 32 medical institutions throughout the state were selected for this study. Of these, 12 hospitals were in rural areas, because to Mrs. Baker's knowledge there have been no comprehensive studies of childhood injuries in rural areas. Specialty referral centers included in the study are the pediatric trauma center of Johns Hopkins Hospital, MIEMSS Shock Trauma Center, the Baltimore Regional Burn Center, the Hand Center at Union Memorial Hospital, and the Eye Center at Johns Hopkins Hospital. The Children's Hospital National Medical Center in Washington, DC was included because it receives many pediatric trauma cases from Maryland.

The criteria for the cases selected were fatalities and hospital admissions ages 0 to 15, with discharge diagnosis relevant to acute trauma, defined as damage from the acute exposure to a chemical or physical agent. (This includes motor vehicle crashes, drownings, poisonings, and so on.)

In emergency rooms, about 40 percent of childhood injuries are due to falls, and 5 percent are due to motor vehicle crashes. However, one sees the reverse when looking at fatalities; 40 percent are caused by motor vehicle crashes, and only about 2 percent are caused by falls. Looking at the sample surveyed in Maryland, more than half of hospital admissions were due to falls, motor vehicle crashes, or poisonings.

There are two distinct types of poisoning that affect children: accidental poisoning in children ages one, two, or three; and suicidal poisonings, which are usually not, but sometimes are, fatal. Beginning at age 13, the intentional ingestion of various types of poisons is a problem of major dimension.

The leading causes of hospital admissions for children ages 0 to 2 are falls, poisonings, and scalds, but the medical examiner's records show that the principal causes of *death* are house fires, motor vehicle crashes, drownings, and assaults. The same four causes of death lead in children ages 7 to 9, although there are relatively fewer children of this age group who are admitted to hospitals or die of injury compared to either the very young or teenagers.

For ages 0 to 9, house fires are an extremely significant cause of children's deaths, partly because they often kill two, three, or four children at a time, usually of smoke inhalation. House fires cause more deaths than motor vehicle crashes, and there are very high rates among black children and in the lower socio-economic groups. Erich Daub, project manager of this part of the study, will be collaborating with Mrs. Baker on the analysis of the results of these data.

When one looks at specific causes of death, there are many that should be preventable. For example, a two-year-old child in Columbia, MD, died from a fall out of a window. It was easy for him to unlatch the screen and push it out. Several children living in similar housing have fallen from windows. Changes in the design of windows and screens could prevent such falls.

Mrs. Baker would like to see a surveillance system developed that would include trauma scores calculated on the basis of prehospital or emergency room data. Currently, many charts do not include information about blood pressure, pulse, or respiration, much less the Glasgow Coma Scale. Yet temperature, which is probably the least relevant factor, often is included.

"It makes me angry that we accept some injuries as inevitable," Mrs. Baker emphasizes. "We must identify the causes and circumstances of the most severe injuries, such as spinal cord injury, disfiguring burns, disabling injuries to the legs, or fatalities, and find ways to prevent them from ever happening."

—Erna Segal

EMS Care Conference Will Suit You to a 'T'

The official EMS Care '85 T-shirts will be available at the conference on June 22 and 23 (preconference seminars will be offered June 21). For information on the conference, which is open to prehospital care providers, physicians, and nurses, contact the Region V office at (301) 773-7970. Plan to attend and celebrate the Best Care Anywhere!

Stop Idling Your Ambo

Letting the engine of your ambulance idle for even short periods of time could be potentially dangerous for your patients, especially patients with severe emphysema or anemia. When the engine idles, more carbon dioxide is produced because engine combustion is less efficient. This carbon dioxide penetrates the patient compartment even when the doors are closed. Although the build-up of carbon dioxide may be relatively low and may not affect ambulance personnel, patients with respiratory problems or anemia have lower tolerances and could be placed in a life-threatening situation. Remember: don't let your engines idle.

Field Notes

By William E. Clark, State EMS Director

In February 1973 the development of the Maryland EMS System was initiated by Executive Order of then Governor Marvin Mandel. Since that time, under the leadership and foresight of Dr. R Adams Cowley, the first fully integrated statewide system of emergency medical services has become a reality.

The early years produced concepts that changed the way traditional medicine was practiced in Maryland. The "Golden Hour"; bypassing of hospitals to obtain the needed level of care; prehospital providers being state-trained and certified as EMT-As; CRTs providing advanced life support in the field as physician extenders; aggressive clinical multidisciplinary teams to treat critical trauma victims; "box"-type ambulances rather than Cadillacs; and MedEvac helicopters—all were some of the major advances.

What has emerged in this pioneering effort has been the most advanced EMS system in the nation. We are continuing to grow and become more sophisticated as new technologies and advanced techniques become available. And the spirit of trust and cooperation is becoming stronger among all levels of providers in the EMS system. The bonds between prehospital emergency services personnel, both career and volunteer, and clinical personnel are stronger than ever.

A look at the vital signs of our Maryland System clearly reveals that we are on a great growth curve. The 911 emergency number system will be statewide in July which will help speed citizen access to EMS in times of emergency. Two more levels of advanced life support, aviation trauma technicians and EMT-Paramedics, recently have been recognized by the Board of Medical Examiners of Maryland.

The Maryland State Police MedEvac program, which has been operational for the past 15 years, has transported more than 24,000 patients. In July, helicopter section 6 will be added primarily to serve the upper Eastern Shore.

The EMT-A training and certification program has been studied during the past year, and recommendations have been made to enhance the program. The proposal, once approved by the Maryland Fire-Rescue Education Training Commission, will become effective statewide in July 1986. Elements of the proposal include more flexibility in training, the ability to gain credit for some self-study and previous experience, and modularization of the training to make it standardized and to better link it with the first-responder program. Trainees will have more options open to them to allow them to successfully reach certification.

The important roles of REMSAC and the regional EMS advisory councils are being reaffirmed. The role and responsibilities of the regional medical director are being better defined. The prehospital care research advisory committee is still in its infancy but several important studies are already on the drawing board. Communications between the state EMS agency and the 23 counties and Baltimore City continue to improve. Local jurisdictions and major organizations are being involved with proposed changes in the system. And many of the fire departments throughout the state are placing more emphasis on the life-saving work of EMS by adding more units and upgrading services to provide more advanced life support.

Probably the strongest vital sign of our system is the support we have received this year from the state capitol. Governor Harry Hughes has provided his full support and leadership to three critical areas of need within the system through new major initiatives in his state budget that was approved by the members of the General Assembly. A new State Fire, Rescue and Ambulance Fund, amounting to about $5 million in its first year, was created effective July 1 to provide badly needed direct state financial assistance to the local jurisdictions. A grant of $21 million to start construction of a new MIEMSS Shock Trauma Center, which should be completed in late 1988, was approved. And finally, a $1.1 million increase in annual funding to the state EMS agency (MIEMSS Field Operations) to replace and upgrade the statewide EMS communications system (over the next decade) and to meet increased training needs of field providers was approved.

All of this adds up to one thing. The citizens of Maryland have a system of emergency medical services that is second to none. It is a reality that grew out of the belief that mortality and morbidity could be significantly reduced through a systems approach to EMS. We all have been a part of this tremendous effort. Together, we have tranformed a dream into a system that the citizens of Maryland are justifiably proud of and that they can depend on in time of need. Let us not lose sight of our historical roots. This is not a time to become complacent but rather a time to recommit ourselves to continue in pursuit of excellence.

Regions to Compete In State Olympics

Winners from regional competitions will participate in the statewide EMS Olympics on June 21 from 7 to 10 pm at the Montgomery County Public Services Training Academy. The playoffs are part of the EMS Care '85 weekend.

When this newsletter went to press, the results of the regional EMS olympics were available from two regions.

Region V

Teams from the Prince Georges County Fire Department and Laurel Volunteer Rescue Squad won the ALS and BLS competitions, respectively, during the Region V EMS Olympics on April 27.

J. P. Medani, Rita Vanderbosch, and Sherrie Shifflet were on the Prince Georges County Fire Department team. Members of the Laurel Volunteer Rescue Squad team included Leona Rowe, Deborah Fiedler, and Lorraine Lawson.

Region III

On April 20, the Region III EMS Olympics were held. In the ALS competition, Edward Sherve, John Workman, and George Michalowski, from Baltimore City Fire Department, won first place. Michael Chrest, Wendy Bowersox, and Doreen Dutterer from Pleasant Valley Volunteer Fire Company in Carroll County placed first in the BLS contest.

Managing Disturbed or Violent Patients...

"People were getting hurt, because they responded to violence with fear. Instead of having a plan of action, they reacted emotionally. It distorted their judgment. Nobody wanted to handle this, not even me. When Shirley first asked me to help, I said, 'When someone touches my body, I defend myself. That's my training.' I just kept saying, 'No, Shirley.' "

Nine years ago, Shirley Zarfos, RN, associate director of nursing in-service at Springfield Hospital Center, finally persuaded Robert Eugene Lippy, LPN, nursing services supervisor, and a second-degree black belt in karate, to help her develop a program to manage violent behavior. Designed to meet the needs of the staff, the program also minimizes injury to patients.

The program explains the causes of aggression; the assault cycle, including triggering, escalation, crisis, recovery, and post-depression phases; prevention, including self-protection and patient management; physical restraint techniques, based on considerably modified karate techniques, but not including hitting or kicking; legal issues; and what constitutes physical, psychological, and verbal abuse. It is now a requirement for the 850 nurses at Springfield, and is available to other staff members. It has been demonstrated at institutions in and out of the state, and was enthusiastically received at the national convention of the American Psychological Association last year. Because the program emphasizes respect for the patient's rights, negotiation rather than the use of force whenever possible, strict accountability for any injuries, and documentation, it can have applications for the needs of prehospital providers and emergency department and hospital staff dealing with persons disturbed or violent due to drugs, alcohol, or psychosis.

When Bruce Regan, MD, became director of education for the Mental Health Administration of the Department of Health and Mental Hygiene, he wanted to establish a similar program for the public sector; Ms. Zarfos and Mr. Lippy present one of the two-hour sessions of this course. Dr. Regan evaluated the Springfield program, and has implemented it in other state hospitals. He also approved the physical techniques for use in all state facilities. Denis Madden, PhD, director of the Violence Clinic at UMMS, helped set up a two-day certification program through the Mental Hygiene Administration for people in other facilities.

Robert Lippy and Shirley Zarfos

"The normal reaction to someone who is acting violently is to go the other way," Ms. Zarfos explains. "Here, we can't go the other way." Prior to the development of this program, it was left to the individual nurse or staff member to find a way to cope with the violent patient. The patient might punch, kick, scratch, spit, or bite, but staff should not respond to anger with anger. As part of this program, they learn to approach with a nonthreatening, nonpunitive, nonjudgmental attitude. They also devised a "Code 3" system, calling personnel from other areas to help. (Sometimes a *show* of force will calm a patient, making it unnecessary to use force.) The administrative staff and nursing supervisors were called in to pass judgment on the physical restraint techniques; any that did not meet with their approval were eliminated. Each individual is responsible for his actions, and must answer to the hospital administration.

A patient is allowed to "ventilate" by talking loudly, screaming, hooting, cursing, or hitting the wall, without being subdued by the staff. They intervene only when he becomes a danger to himself or others. Nurses are taught to recognize the potential for violence by the presence of risk factors, such as clenched fists, angry facial expressions, rigid posture, increased motor activity (pacing, excitement, irritability), rage, suspicion of others (delusions, hallucinations), or repeated requests or demands. At this level, the proper intervention might be to listen to the patient to determine what happened to trigger the incident, and what might be done to de-escalate it; approach the patient quietly, with a calm voice; allow verbal expressions of hostility; provide a nonstimulating environment (away from the crowd, if possible); and provide physical outlets for aggression, such as walking, tearing paper, or hitting a wall.

A prehospital or hospital provider might make the mistake of trying to comfort, by putting his arm around the patient's shoulders. "You don't touch unless you intend to control. Keep your distance. Allow him his space. Keep an arm's length and a big step away—maybe even further," Ms. Zarfos stated emphatically. "You do not pat, comfort, and sympathize with someone who is very upset. That can provoke him into violence quicker than you can speak."

Mr. Lippy explains, "Try to negotiate—his anger might be justified. He needs to hear that; he needs to spout off. Sometimes a person has feelings of anger and doesn't know why, but that's not the high percentage. Allow him to act out. Call him by name, if possible, and tell him yours; it builds rapport. Start joking. Say something like—'Hey Joe, what's happening? What's going down? What are all these people doing here?' He'll holler and cuss, and you say, 'Hey, man, I'll go, but first, can I help you while I'm here?' The longer you hold him at one place, the better. Let him know, 'Your behavior is way out of line, and you're going to hurt yourself and others. We're going to help you.'

"Everything we do at this point is directed toward helping the patient regain his control. Losing control is frightening to a patient, and we don't want to escalate his fears. Keeping your voice calm has a calming effect on him.

"People burned out on drugs are so far out they don't respond in the same way. Be more careful. Their pain level is reduced—and their strength is increased. They don't feel anything. Their knowledge is impaired—you can't reason with them. You need to know the signs and symptoms of drug users: bloodshot eyes; running drippy nose; sniffling; dilated pupils. Pick up on these things. Whether people are on drugs, alcohol, or are psychotic, the outcome is the same. They lose control, and you have to gain control.

"Sometimes that includes running. If you know in your heart you can't control that person, get help. Don't take on someone you can't handle, just because

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...Patients' Rights and Strict Accountability

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you're there. That's poor judgment. Believe it or not, that was something we had to teach our nurses, that it was all right to withdraw to get help."

Mr. Lippy responds to as many Code 3 calls as possible. If the patient has been trained in the martial arts, he'll say, " 'Hey—you're good. What system are you in? I've had a little karate, tell me about yours.' The idea is not to say 'I know it, and I can handle you,' but to let him feel good about it. I'll say, 'Apparently you need our help. Please let us help you.' You must have a plan of action. If you get angry because you've been kicked or spat upon, you'll overreact."

"As a person becomes more agitated, it's necessary to change your verbal approach from one of reasoning and using a lot of words, to one of shortening your sentences, and being very clear and concise," Ms. Zarfos explains. "As a person loses control, his perception becomes distorted. Words scramble. He distorts the message. So change your manner of speaking, maybe even giving instructions or directions. Tell him what you want him to do, clearly and simply. Keep your voice calm. Don't meet his escalating level of agitation—that's abuse." At this level, the patient might be given a sedative or tranquilizer.

"When all else fails, what do you think about when you must use physical measures? Your own strengths and weaknesses become very important; also those of your coworkers. These should be determined during practice sessions. Can you manage the patient, or should you call for help? If someone is about to throw an ashtray, you can use a jacket or mattress as a shield. Think about what you are wearing that can be harmful. Take off your glasses, if you don't need them. Take off your watch. Looped, pierced earrings can be caught on clothes during a struggle; necklaces can be a choking weapon. Take off rings—if someone squeezes your hand it will hurt, and your attention will go to the pain instead of the patient. Keys, pens, and pencils are easy weapons the disturbed person might grab, and can be used to stab. Spike heels cause ankle damage. Take off jackets, sweaters, and vests—the patient can grab them and throw you around with them. They're not needed anyway; these situations generate plenty of heat.

"Formulate a plan; that way, each person has only one thing to remember. (For example, you take the right arm, I'll take the left.) Minimizing injury means that while the patient is kicking, biting, spitting, or hitting, we are not going to do these things back to him; we're going to subdue him without hitting, kicking, or breaking his arm."

The staff will feel an adrenalin rush during the physical management of the patient, and has to work it out after the episode is over. It's important to talk about feelings of fear and anger as a group, if possible. What did we do? What could we do differently next time? What seemed to get a response? What were you thinking or feeling? At Springfield, the staff speaks to patients who witnessed the incident, who might identify with the violent patient. They are asked, "What can you do instead of becoming violent?" Discussing the alternatives can be constructive and beneficial. Staff must evaluate the incident by documenting exactly what took place, on a form that is used for learning and practice purposes at present. The information also goes into the progress notes in the patient's record. If it is determined that too much force was used, the staff member can be sent back to take this program again, or possibly face disciplinary charges leading to dismissal. Patients usually apologize to the staff for losing control, and the staff usually apologizes to the patient for having to subdue him.

Ms. Zarfos suggests the following publications for further reading on the subject:

- Goode, WJ: Force and Violence in the Family. *Journal of Marriage and the Family,* 33 (4) 624-636, 1971.
- Harbin, HT and Madden, DJ: Battered Parents: A new syndrome. *American Journal of Psychiatry,* 1979, 136 (10) 1288-1291.
- Lion, JR and Madden, DJ: Treating the Violent Offender. In Kutash, IL, Kutash, SB, and Schlesinger, LB (eds) *Violence Perspectives on Murder and Aggression.* San Francisco, Jossey/Bass, 1978.
- Madden, DJ and Lion, JR (eds) *Rage, Hate, Assault and Other Forms of Violence.* New York, Spectrum Publications, 1976.

For additional information on Springfield's program to manage violent behavior, contact Shirley Zarfos at 301/795-2100, ext. 492.

—Erna Segal

Treating Children at the Scene

Barbara Darr, a CRT from Hagerstown in Region II, comforts 4-year-old Eric Shrader after he was hit by a car. (Photo by Bob Leverone courtesy of the "Hagerstown Herald-Mail.")

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Emergency Medical Services Systems
for
Maryland Institute

Published monthly by the

Legislature Passes Laws Affecting EMS

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House Bills

HB 453: Life-sustaining Procedures. This bill provides that a person may execute a "Living Will" directing that certain medical procedures be initiated, continued, withdrawn, or withheld under certain circumstances. The bill provides protection for prehospital providers.

HB 573: Hospitals—Language Competency. This bill requires the State Board of Examiners of Nurses, the State Board of Physical Therapy Examiners, the State Board of Medical Examiners, and the State Board of Podiatry Examiners to require that an applicant for a license to practice certain health occupations demonstrate oral competency in English.

HB 873: Creation of a State Debt—Suburban Hospital. This provides for a $250,000 grant to Suburban Hospital for the renovation, rehabilitation, improvement, and expansion of its shock trauma center and emergency department.

HB 998: Fire-Rescue Education and Training Commission. This bill alters the composition of the Maryland Fire-Rescue Education and Training Commission, adding one volunteer and one paid emergency services person. It requires that the new members come from jurisdictions not represented on the commission as of June 3, 1985.

HB 1070: Health Care Cost Containment—Health Insurance. This bill requires that nonprofit health service plans that specify low-cost hospitals and provide health care accordingly shall base the designation of low-cost hospitals on information that excludes specified costs, such as the cost of trauma care at the areawide trauma centers.

HB 1071: Health Care Cost Containment—Utilization Review. This bill requires each hospital to establish a utilization review program for all patients in the hospital. The program must be approved and recertified every two years by the Secretary of Health and Mental Hygiene, to be sure it meets the minimum requirements established in this bill.

HB 1072: Health Care Cost Containment—Health Services Cost Review Commission. Futher defining the jurisdiction of the commission, this bill includes the authority for the commission to collect data on physician practice patterns, but requires that this information remain confidential and be released only to specified groups. It allows the commission to take into account objective standards of efficiency and effectiveness. The bill also requires the commission to report annually to the General Assembly on certain issues.

HB 1126: Creation of a State Debt—MIEMSS. This bill provides for a $21 million grant for the University of Maryland Medical System for the construction of a new Shock Trauma Center facility. An additional $10 million of unrestricted funds was agreed upon for next year.

Several bills were introduced during this session regarding mandatory use of seat belts. The Senate passed a weakened version of SB40, but the House Judiciary Committee was unwilling to give a favorable report for any of the bills, including the Senate version. As has been the case in previous years with mandatory motorcycle helmet legislation, the Judiciary Committee is reluctant to pass legislation that impinges on citizens' personal liberties, one being the right to choose. It is hoped that this attitude will change with time and that in the future the Maryland legislature will enact both mandatory helmet and mandatory seat belt legislation.

—Pam Metz