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efforts if the form will not be admitted into evidence or will provide only a weak defense to the patient's later allegation of abandonment by the EMTs.

Some poorly worded release forms may fail to convince a jury that the patient really made an *informed* refusal and that he really intended not to hold the EMTs liable for what could otherwise constitute a negligent failure to treat and transport. Other release forms may never get to the jury if the court determines that the form is not adequate as a matter of law. Therefore, all release forms should be reviewed carefully by an attorney familiar with the laws of the jurisdiction where the form is to be used, since applicable laws will vary. In Wisconsin, for example, there is an obscure rule of evidence that a document signed by an injured person within 72 hours of the injury is not admissible in court. There are some exceptions to this rule, however, and the form must be carefully worded to fit within such an exception. Wisconsin law also provides that the patient must be given a completed and signed copy of the form. Similar laws may apply in other states.

Peter B. King
Attorney at Law, EMT-I
Fontana, Wisconsin

In response to your article "Refusal of Care" (April 1985), an EMT cannot force care on a responsible adult who does not want it. However, the EMT can talk to the person. That's where a problem arises. It's not how to talk to the patient, but what to say. EMTs are not social workers, and we don't like to cut patients loose who may indeed have a serious problem. This should be motivation enough to read up on crisis management and personal interaction. After all, the patient is human, not just another emergency medical problem to solve.

Steve Siptrott
Utica, New York

Austin, Tulsa in Good Company

It was pointed out to me recently that in your May 1985 issue the cost of the EMS operations in Austin was referenced in the article entitled "Tulsa, Public Utility Model Revisited, Part 3." After reading the article, I have very little doubt in my mind that the program in Tulsa, Oklahoma is, in fact, a fine service. However, I would take issue with the remarks made by its author concerning the Austin EMS Department.

While I direct a third service in Texas, I don't believe that every community ought to have one. I firmly believe a community's EMS system ought to reflect the public's wants, desires, demographic characteristics, and financial resources.

It appears that the author is galled by the fact that we in Austin have such strong citizen support. For example, last year the city of Austin took a $958 million bond package with 26 different propositions to the voters. The EMS proposition for $500,000 received the highest majority of public vote of all propositions.

Dennis Simmons, Director
Emergency Medical Service Department
Austin, Texas

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Jack Stout replies: *In praising the efficiency of one system, I had no intention of offending another. My only reference to Austin was that if Tulsans subsidized EMS at the same per capita level as do the citizens of Austin, Tulsa's fees would be $0 and there would be $50 left over for each patient served.*

I called Dennis Simmons to update my figures on Austin's subsidy level. Austin's current subsidy level would now produce a $71 per transport profit in Tulsa with fees of $0.

Efficiency is an important aspect of system performance—not as important as quality of service, but important.

Mr. Simmons has agreed to cooperate with an "apples-to-apples" comparison of both quality and efficiency in the Austin and Tulsa systems. Frankly, neither system could be in much finer company.

Dick's "Tricks" Tips Tripped?

Congratulations on your fine publication and the contribution you continue to make towards professional growth and development in EMS. I always enjoy and value the *tips* offered by Thom Dick. I believe, however, that the recommendation to apply an oxygen mask without providing an oxygen supply to the patient should be reconsidered.

First, Mr. Dick's statement that the primary concern of treating the patient's anxiety is correct. Second, he is also correct that most patients do not react well to the bag (it increases their anxiety). Most patients, however, do not "need to be brown-bagged," they need to have their PCO_2 levels restored to normal to dilate the vessels and shift the oxygen dissociation curve of the hemoglobin to combat hypoxia.

I agree that an oxygen mask should be applied to the hyperventilator. Oxygen should also be administered. This will reduce the patient's anxiety. The hyperventilation will self-correct very quickly and the crew will be spared many combative experiences. In addition, it is not possible to differentiate hyperventilation due to anxiety from that due to pneumothorax or pulmonary embolism without blood gases. The medicolegal consequences of treating severe respiratory emergencies by increasing hypoxia are clear.

I refer you to Dr. Ronald D. Stewart, Medical Director, city of Pittsburgh Emergency Medical Services Department for confirmation and amplification. After all, we were using the mask and oxygen method for many years prior to his arrival in Pittsburgh. Paper bags et al are no longer in use.

Thank you for your consideration and keep up the good work.

William Raynovich, Jr., EMT-PII, M.P.H.
McKeesport, Pennsylvania

Thom Dick replies: *There* are *many kinds of hyperventilation, and Mr. Raynovich is right—I should have clarified the fact that I was referring only to* anxiety *hyperventilation syndrome. The context seemed clear to me and still does, but I hope the wording didn't confuse anyone.*

As being able to differentiate anxiety hyperventilation syndrome from various other types of hyperventilation (for which treatment includes high-concentration oxygenation), that's part of the rescuer's job. *True, it can only be confirmed by blood gas studies—maybe an hour or more later,*