Maryland
EMS
NEWS
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Coping with Hurricane Gloria

Firemen found less than ideal conditions when they responded to a fire as Hurricane Gloria battered Ocean City last year.

Hurricane Gloria flooded Ocean City, MD last year.

"As we looked up the alley toward 13th Street an entire section of boardwalk floated by with the light pole and street sign straight up like an arrow. That causes some concern." That understatement, made by Capt. Steve Price, of the Ocean City Volunteer Fire Company, Inc. (OCVFC), describes the battering of Ocean City by Hurricane Gloria last year. Hurricane season means special planning and extraordinary demands for emergency services. The story of how Ocean City dealt with the hurricane might help others plan for similar situations.

With the hurricane forecast for Thursday, September 26, an emergency operations center was opened at 9 am that day to prepare for the storm. There was soon an onslaught of approximately 350 members of the press and more phone calls than the communication center could handle. Emergency personnel were put on standby.

At 1:05 pm Phase II of the Ocean City Emergency Evacuation Plan was put into effect by the mayor and the city council. It stipulated that all nonresident property owners, vacationers, and visitors were urged to evacuate the island; all residents of mobile homes were urged to seek other shelter; schools in Berlin were to be set up as emergency shelters beginning at 4 pm; the Route 50 drawbridge was to be closed to boat traffic after 4 pm; and residents were urged to listen to radio and TV for further information.

A hurricane watch was posted for Ocean City at 3 pm and three possible paths were predicted for the storm. Phase III of the evacuation plan was put into effect, in which total evacuation of the town was *requested* by 11 pm and all incoming traffic was restricted to residents and emergency services personnel. OCVFC firefighters arrived to man all five fire stations.

A hurricane warning was posted for the area at 6 pm with maximum sustained winds expected at 130 miles per hour (mph).

Concern arose at 8:50 pm when it was learned that some people were planning to have "hurricane parties" and "boardwalk watches" during the storm. In response to this concern, "A Proclamation for a State of Civil Emergency" was enacted by the mayor and city council. It prohibited the sale of any alcoholic beverages after 9 pm; closed the beaches and boardwalk; *ordered* a total evacuation of the island by 11 pm; and said that no one would be permitted access to the island after 11 pm without the permission

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Teamwork Battles Hurricane Gloria

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of the mayor and city council. All access into Ocean City was now blocked by Ocean City Police Department and Maryland State Police officers.

As the town began to empty, a few looters were seen, reported to the police, and apprehended.

At 9 pm it was decided that the public safety group, consisting of representatives from the police, fire company, lifeguards, and members of the recreation council would comb the town street-by-street to ensure that the evacuation was proceeding. Whenever a light or an automobile was seen, the people were told of the mandate to evacuate. Some people left willingly. Others, who were more reluctant to leave, thought twice about staying when they were asked for the name, address, and phone number of their next-of-kin. Luckily, the height of the tourist season was past, and the town population was down; thousands were evacuated. Fewer than 100 townspeople were left on the island at the height of the storm.

At midnight September 27, the storm was located over Cape Hatteras, NC, with winds of 130 mph; Ocean City was experiencing gale-force winds. At 5 am the winds were between 70 and 80 mph. "It felt like it was ready to let loose," says Asst. Chief Steve Cropper. It was decided to split the command center between OCVFC headquarters and the Maryland State Police Barracks at Berlin. Second Asst. Chief John Guntow, of the OCVFC, became the fire company representative in Berlin. Apparatus #711, #712, #713, #714, #715, and #718 were moved from the island onto the mainland to either OCVFC Station #5 in West Ocean City or to Berlin. All remaining apparatus were moved outside for fear that fire station doors might malfunction due to the strong, gusty winds. Positions were assigned on the remaining apparatus for all the remaining personnel. Personnel rosters were completed for all stations, and the stations were required to report their status to the fire company headquarters at 15-minute intervals.

A report was received of a strong odor of smoke in the vicinity of 11th Street and the bay. Engines #702 and #709 and Rescue Unit #707, with Capt. Price and Asst. Chief Cropper and 10–12 men, responded. Water in the street was over the runningboards of the apparatus and it was so difficult to see that they could not locate the fire at first. Rescue #707 found it in a three-story wood frame building between 12th and 13th Streets, just a house away from the boardwalk. Chief Roger Steger and 10–12 men responded from fire company headquarters. A second alarm brought Engines #716 and #717 and Tower #705, as well as Engine #701 from Fire Station #5. Fire Marshall Dave Lankford suffered a heart attack on the scene. Heavy fire was encountered—under less than ideal conditions.

The wind was so strong that there was a danger that firefighters in the most critical areas might be blown into the water. Eight of the men had to wear turnout gear, life jackets, and air packs.

Water rolled through the alley from the ocean. Firefighters were knocked down and rolled in water over their waists. Luckily the water was not cold. Bunker pants and boots filled up with water and became so heavy it was impossible to walk in them; they had to be removed and emptied periodically. Four portable radios were lost, along with 18 beepers that the men couldn't bear to leave at the station. The boardwalk broke up and pieces washed down through the gap between the buildings.

Pilings, pieces of boardwalk 20–30 feet long, 12 x 12s, and 10 x 10s were picked up and slammed into buildings and apparatus. Firefighters had to drop what they were doing and run, to avoid being hit by the timbers. "We were afraid to leave the fire because it might have leaped and jumped and taken out several blocks of buildings," says Asst. Chief Cropper. "We decided to make a stand and hold this fire."

The rescue truck had been parked where there wasn't a drop of water when the firefighters first arrived on the scene. But as the storm progressed, water was washing over the truck from front to back; they had to drive it away with the ocean pounding on it. The Sutphen Tower was parked on the street, but blowing sand buried it so deeply that the compartment doors wouldn't open. Firefighters took straight steam nozzles and jetted around the tires, put the truck in gear, engaged a big Caterpiller frontend loader, and moved the tower about 10 feet until the main drive shaft was wrung in two.

"We finally did break into the apartments to the south of the fire building, and we put master streams in the windows," says Capt. Price. "We were feeling safer until another captain from a ladder truck pointed out that we were on the second floor and the waves at the window were at eye level."

Chief Steger says, "In my 14 years of experience with this fire company these are the worst conditions we have ever had to face in fighting a fire. And I hope that we—or anyone else—never have to face such conditions again."

There were other fires in Ocean City during that storm. A motel fire required the initial response of Engines #703 and #704 and Ladder #706 from the 74th Street Station; a second alarm

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EMS & Hurricane Gloria

What was happening with emergency medical services in Ocean City during Hurricane Gloria? Incredibly, even with high-speed wind gusts, floating timbers, and flooded streets, the only call for EMS was for the fire marshal who had a heart attack. According to Billy Bounds, EMS supervisor for Ocean City, ALS crews were at all five fire stations and went on every fire call as they always do. But with the town evacuated, there were few citizens around to get hurt.

As a precaution, a MIEMSS team stood by in Berlin as a backup to local and regional resources in the event they were needed. The MIEMSS team consisted of William E. Clark, state EMS director; Ameen I. Ramzy, MD, state medical director for field operations; Mary Beachley, RN, trauma nurse coordinator; David Skurdahl, MD, anesthesiologist; Ronald B. Schaefer, director of prehospital training and certification; and other field operations and medical staff. Marc Bramble, Region IV EMS administrator, acted as the EMS liaison at the Ocean City Fire Department command post.

There were large numbers of people gathered at the evacuation centers. Some of them needed medical attention, which was provided by local medical personnel. The MIEMSS medical team did a periodic check on patients at the evacuation centers to assist the medical staff if necessary.

MIEMSS Announces Staff Changes

Several staff members have recently joined MIEMSS, and other staff members have recently changed positions. The new staff members in the Field Operations Program include the following.

Eugene L. Bidun, Director of Communications. Previously with Artel Communications, a fiber optics company in Worcester, Massachusetts, Gene holds degrees in electrical engineering and business administration from the Pacific Western University in Los Angeles.

Kenneth L. Young, Director of Prehospital Care. A former lieutenant in the Baltimore City Fire Department Medical Bureau, Ken is certified as both an EMT and CRT instructor. During the 18½ years he worked for the fire department, he also worked part-time for MIEMSS Testing and Certification as an evaluator for EMT practical exams and CRT instruction.

Larry E. West, Associate Director of Testing and Certification. Larry was a teacher for 18½ years for the Maryland School for the Deaf, in Frederick. He has been a part-time instructor on the EMT level for MFRI since 1974, and has worked closely with the Frederick County ALS program as a CRT. Larry is a nationally registered EMT-P.

Gerald G. Galvin, Assistant Administrator of Region III. A graduate of the emergency health services program at UMBC, Jerry studied the clinical paramedic module and is certified as an EMT in Maryland; an EMT and CRT instructor in Pennsylvania; and a National Registry EMT. He was formerly the education coordinator for the four counties around Altoona, Pennsylvania.

Steve Roth, Assistant Administrator of Region V. A 1986 graduate of the emergency health services program at UMBC, Steve has had a long involvement with fire and EMS services. He is a volunteer EMT at Hillandale Volunteer Fire Department in Silver Spring.

The following staff members have changed positions:

Dave Ramsey, Director of Regional Programs. Dave has been, and will continue to be, the regional administrator for Region I. In addition, he will be the overall director of all the regional programs.

John Donohue, Administrator of Region III. John was the first and only graduate of the emergency health services program at UMBC in the class of 1982. He was formerly the assistant administrator of Region III. A volunteer CRT at Cowenton Volunteer Fire Company in White Marsh, Baltimore County, John is studying to be a CRT instructor.

George P. Smith, Associate Director of Prehospital Care. George was the former administrator of Region II and will continue to take an interest in that region, although he will be working with Ken Young in prehospital care. Originally a graduate student in anatomy at the University of Maryland, George got his start with MIEMSS scheduling volunteer drivers for the Maryland Regional Neonatal Program.

In addition, the National Study Center for Trauma and Emergency Medical Systems (an affiliate of MIEMSS), has a new executive director. **Lloyd Abbott**, formerly an army major, worked for the US Army Medical Service Corps at Walter Reed Army Medical Center for 12 years before joining the National Study Center. As chief of the plans, operations, and training division at Walter Reed, he helped organize the National Disaster Medical System.

—Erna Segal

Field Notes

By William E. Clark, State EMS Director

Every other minute in Maryland, the public is calling for help... they need emergency medical services. And the EMS providers routinely perform their professional life-saving work with skill and precision.

But, on occasion, unusual environmental conditions require extraordinary planning and personal risk to ensure the delivery of emergency services.

Hurricane Gloria was one of those events. As Gloria roared up the east coast, forecasters were calling it the potential storm of the century. All Maryland State Police helicopters were grounded and many were moved to Baltimore. Areas like the lower Eastern Shore were isolated.

Faced with high winds, heavy rain, and highly dangerous flooding conditions, emergency services personnel performed in the most exemplary manner under extreme threatening conditions.

It is times like this that you are able to see what the true fabric of the EMS system is made of. And throughout Maryland, all elements of the system pull together to ensure the continuity of emergency care to the citizens of Maryland. You all deserve the highest praise and recognition for this extraordinary dedication to your communities.

Role of Commerical Ambos

In response to recommendations from REMSAC and DEMSPAC, R Adams Cowley, MD, director of MIEMSS, appointed a task force to study the role of commercial ambulances in the state.

The issues to be studied include: the role of advanced life support versus basic life support; interhospital transports; the potential of emergencies on board a commercial ambulance; emergency warning devices and interference with fire/rescue apparatus; communication and radio equipment; the relationship between commercial ambulance service and the existing prehospital provider system; the possibility of regulations for commercial ambulances; and recommended mechanisms to protect the consumers of ambulance service in Maryland.

Serving on the task force are Chief Paul Reincke of the Baltimore County Fire Department, chairperson; Kathleen Edwards, RN, PhD, vice chairperson; and members Billy Bounds; William E. Clark; Chief M.H. (Jim) Estepp; Robert Harsh; Leon Hayes; Chief Michael W. Jachelski; John Marsh, MD; Larry May; Ameen I. Ramzy, MD; Amy Spanier; and Chief Robert Wilson.

The task force report is to be submitted to Dr. Cowley by November 28, 1986.

If Preemies Need Prolonged Care

Ten years ago, if a baby weighing 1200 grams (about 3 pounds) could be kept alive and discharged from the hospital it was considered a triumph. With today's technology, babies weighing 500–600 grams are kept alive. However, these babies are younger and consequently have more central nervous system and pulmonary problems, creating a need for skilled long-term care.

This care requires a team effort that links the parents with physicians, nurses, therapists, psychologists, and social workers to provide the necessary support system and funding.

According to Kathy Aoki, former nurse coordinator for the Maryland Regional Neonatal Program, a principal long-term problem with extremely premature babies is bronchopulmonary dysplasia (BPD), which seems to occur as a byproduct of the oxygen and respirator therapy needed for survival. The exact etiology of BPD is unknown. However, it is known that babies with hyaline membrane disease who are put on respirators with high oxygen concentrations develop damaged airways. Research is needed to pinpoint the cause of BPD, which persists for months to years after birth, resulting in chronic respiratory insufficiency that requires still more oxygen therapy. Some babies may have a predisposition to BPD because of genetic factors, such as parents who have asthma or allergies. If the baby can be brought through the initial difficult period, many cases are resolved when the child reaches 2–2½ years of age. More difficult cases can last until the child is 4 years old and beyond.

Babies with BPD and other problems of prematurity may function at a much younger level than their chronological age. They face the risk of sudden death, metabolic disturbances, kidney stone formation, recurrent pulmonary infections, and unexplained fevers due to what seems to be an abnormality in their body temperature control mechanism. Many babies cannot coordinate the feeding activity and must be fed through a nasogastric tube. With all the support equipment, tubes, and monitors, "bonding" is often difficult for both the baby and the parents.

"Infants who survive overwhelming physiological and psychological insults as a result of severe respiratory disorders and their treatments are not left unscathed," says Nancy Bell, PhD, director of psychology at the Mount Washington Pediatric Hospital, a postacute hospital for long-term care. "We must expect behavioral differences in these children. Imagine what an infant may potentially learn from the experience in a neonatal intensive care unit (NICU), a long-term stay in a postacute hospital, and finally in a family home. He may learn not to attach to any one person because he comes in contact with so many, day and night. He may learn to be always in a state of readiness because at any time someone may come in and take blood or perform other procedures. He may learn fear from the approach of other people that outweighs intrinsically friendly acts like touching or feeding. His fear and deprival may be expressed by food refusal, gagging, spitting, and vomiting. He may learn not to move, initially because he is too weak, and later because he is too restricted by tubing. And he may learn to remove this tubing, because it brings an immediate response from a nurse, and the cause and effect are evident to him."

When a baby is released from the NICU, the best possible environment for him is his home, if possible. Home health care nurses may make it possible for parents to keep at home the infant requiring monitoring, oxygen, or other medical care, but taking care of a baby on a ventilator is complex and includes operating and troubleshooting the equipment.

In some cases, and even in the best of families, the home may not be the best place for the baby while he is still in need of skilled medical attention. He may need an interim facility between the hospital and home. Candidates for postacute hospitalization include babies with a need for continued mechanical ventilation, or who have severe bronchospasms, severe fluid sensitivity, tracheostomy, or gastrostomy; infants whose parents don't understand the illness or are overwhelmed by the complexity of care; or infants whose parents are judged to be unbonded.

A long-term facility can provide a less stressful, home-like setting for the infant's recovery and the parent's education about the condition; training; a safe and supportive environment for bonding (NICU infants are more at risk for child abuse); evaluation and treatment of developmental disabilities; and a logical transition from professional care to family care. MIEMSS and the Mount Washington Pediatric Hospital held a joint conference recently to explore the spectrum of care from the hospital to the home.

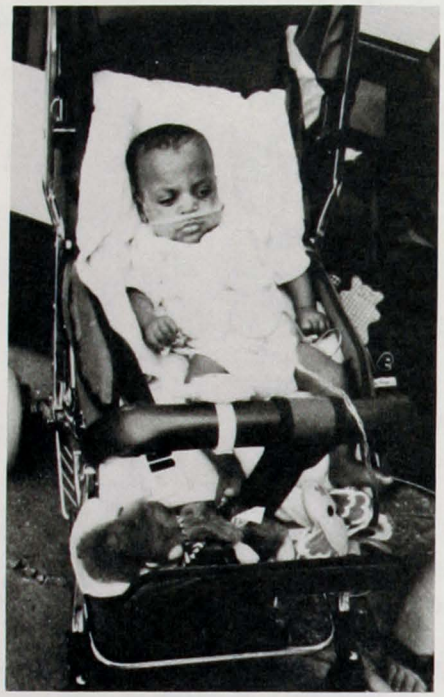
A first-hand description of life with a BPD child was given at the conference by Marietta Nolley, whose second child, Tyson, still has BPD at almost 4 years of age. "Tyson's first year of life was long and difficult, both emotionally and physically. My 7-year-old son, Dawson, was put on the shelf for a while, and our good, strong marriage was tested constantly. When all one's energy is spent trying to keep one member of the family alive and well, things that shouldn't be neglected, are. Dawson's schoolwork suffered, showing us that we needed to return to some degree of normalcy; we had to take stock of our home life. As demanding as Tyson was, we still couldn't give her our undivided attention. As professionals you will never understand the impact that a complicated child has on the family; it is far greater than you can imagine.

"Tyson had a strong personality from the first day—she is a 'feisty broad.' She is a survivor. Being sick has been an inconvenience, but she hasn't let it get in her way. She has managed to fall down steps, drive 'Big Wheels,' swim, and take a trip, all while attached to tanks of oxygen by 100 feet of tubing. We try to treat her as a normal child. The simple act of swinging on a neighbor's swingset requires untangling the tube and making sure it doesn't get caught on rocks or the gate. She wants to follow the neighborhood kids, but can only go as far as her tubing allows. We do use a portable unit at times.

"A major part of our success is that we have been consistent. We have had the same nurse for 3 years, and Nurse Rosemary has been a godsend. Her picture is on the table with the pictures of the rest of the family. And another factor is that we do not burden Tyson with our anxieties. That is probably the most taxing and exhausting part. As professionals, you can be most helpful to parents by listening and allowing them to use you as a sounding board—that is an enormous help in a situation like this."

—Erna Segal

EMTs Take Sick Infant as Foster Child



"John" at the picnic/shower in his honor.

NICUs Now Full

The complications of extremely premature, low-birth-weight infants are resulting in overcrowded neonatal intensive care units (NICUs). Babies weighing 600–800 grams need acute intensive care for months. With new babies being brought to the NICUs all the time, the NICUs have filled up and are beginning to overflow their capacities.

"We have filled up the NICUs in the Maryland system, and we have had to send babies out-of-state," says Cheryl Y. Bowen, RN, MA, administrator of the Maryland Regional Neonatal Program. "In the past we have had a reciprocal program with Washington, DC, when we had a temporary overflow, but now they are in the same situation we are—very full. We are now transferring babies to Wilmington, the next closest center, and have already referred some to Harrisburg and Hershey."

Finding an available NICU bed can take hours of cajoling, entreating, and strategy. For example, pediatric ICUs will sometimes take babies with congenital defects, although they would rather not take babies with the problems of exteme prematurity. Ms. Bowen says, "Sometimes we get a call saying 'We're really full, but if no one else will, we'll try to squeeze in a bed for you. Call us back.'"

Maryellen and Randy Harper at the shower given by MRNP staff.

Extremely premature babies have special problems. But luckily there are very special people who are willing to turn their own lives around to help them. For example, people like the two volunteer EMTs who took for foster care a baby on a monitor who needs special feedings, a gastrostomy tube, and oxygen.

In September 1985, twin brothers, John and James (their names have been changed to protect their privacy), were born three months prematurely to an unmarried teenage mother. Their combined weight was five pounds. The infants were transported to Sinai Hospital's neonatal intensive care unit (NICU) by neonatal transport nurses (NTNs) of the Maryland Regional Neonatal Program. The NTNs were driven and assisted by a married volunteer EMT couple, Randy and Maryellen Harper.

The Harpers often work together on weekend neonatal transports. Although they have transported many sets of twins before, this transport was extremely difficult, Maryellen says. "John had to be resuscitated three times before he reached the hospital. It looked as though there was no way he would make it."

John fought so hard to live that the Harpers kept coming back to the Sinai NICU to check his progress. He developed sepsis, and later needed his gallbladder removed. It was touch-and-go for a long time.

His twin brother James fared better. By March, although he was still on oxygen, James was well enough to be put into foster care. It was hoped that John would join his brother when he was discharged from the hospital.

When John became emotionally and socially ready to respond to outside stimulation, the Harpers brought him toys, just as they had brought a mobile to James when he was in the step-down unit. When John was ready to leave the hospital around Memorial Day, James's foster mother was asked to take him. She declined, because John still needed too much medical attention for her to handle both infants. The NICU staff suggested that the Harpers take John as a foster child.

Both of the Harpers work full-time: Maryellen is safety engineer for Alexander and Alexander, a Baltimore insurance broker; Randy is the safety and security director for Good Samaritan Hospital. But on June 11 they brought John home. They took turns staying home from work, first alternating weeks off, then days off, until they could find a babysitter with the necessary experience for taking care of an infant with medical problems.

John is thriving under the Harpers' conscientious care and individualized attention. He now makes eye-to-eye contact, and is beginning to use his hands to grasp. In fact, it is hard to keep the cannula in his nose, because he pulls it out. He has gained weight; at 10 months of age he weighs 11½ pounds.

John has bronchopulmonary dysplasia (BPD) and developmental difficulties, and until recently needed feeding through a nasogastric tube at 2 am. James has only BPD. They will probably both be on oxygen for at least another year.

The Harpers feel that they have a support system between the staffs of the Maryland Regional Neonatal Program (MRNP) and the Sinai NICU. The MRNP staff—the physicians, nurses, and drivers—and their families, had a picnic in June, at which time they gave a shower for the Harpers and John. And when John's primary nurse at the Sinai NICU, Kay Mathias, occasionally babysits for him, she invites other members of the NICU staff to make it a reunion.

Why would people take on such responsibility for an unrelated baby with demanding physical difficulties? Maryellen explains it this way: "This is just an extension of our volunteering. First it was transport, then bringing toys and clothing, then giving him a home. Ultimately we would like to see both twins adopted by the same family, but in the meantime, John's smiles make all the effort worthwhile."

—Erna Segal

Region III

WITH SYMPATHY

The past weeks have not been the happiest for several volunteer companies in the region. Marley Volunteer Fire Company in Anne Arundel County lost EMT George Engle, who was killed in an accident. Bel Air Volunteer Fire Company lost Joseph O'Brien, a retired member. Level Volunteer Fire Company lost Edwin "Toad" Bowman, and Reisterstown Volunteer Fire Company lost Joe Carter. No words that I could say could fill the voids in those companies, but I would like to share something with all of you which may be of some comfort.

Following is a poem written by Larry Mabe, chief of Level Volunteer Fire Company in Harford County. Larry dedicated it to "Toad" Bowman. Toad was a friend to all and left a very close family behind, who were all somehow involved at Level. With this in mind, I think Larry and Toad would wish me to extend this tribute to all who have passed away.

NDMS

Thanks to all who worked at Swann Park, Havre de Grace, and BWI during the NDMS exercise. If you have more comments, please send them to my office. We will include them in future plans. We can always improve.

WELCOME

Jerry Gavin is now the assistant administrator of Region III. Jerry, a former trauma technician from MIEMSS, also worked in Pennsylvania at an office similar to this one.

—John Donohue
301/528-3997

Trauma Symposium

The 9th National Trauma Symposium, to be held November 3–5 at the Sheraton Inner Harbor in Baltimore, will focus on trauma as the neglected disease—20 years later. (In 1966, the National Academy of Science/National Research Council outlined the problems of the lack of services, facilities, and care for trauma and emergency victims in its landmark white paper, "Accidental Death and Disability: The Neglected Disease of Modern Society.")

The symposium is sponsored by MIEMSS.

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

Tribute to an EMS Volunteer

This tribute is dedicated to Edwin "Toad" Bowman of the Level Volunteer Fire Company in Harford County Maryland. The most loyal and dedicated ambulance crew member we will ever know. A finer CRT we couldn't produce.

It's 3 am and the night's silence is broke,
your ear leans toward the monitor as the soft words are spoke.

It must be your station cause the covers have flown,
your spouse just wiggles and quivers, then stretches and groans.

You fly out the door and jump into the car,
it sounds like a hot call, hope it isn't too far.

While responding your mind works, it thinks all the while,
reviewing that learned information our brain has on file.

You arrive at the call and it isn't too bad,
just a teen who's all drunk, and a father that's all mad.

So you do what you must, then you haul them away,
cause in our EMS system it just happens that way.

We have all wondered why we do this, jump up in the night,
to greet death, sad and suffering or a knife from a fight.

It's sure not for money or the praise or the joy,
but for that warm sincere smile from that hurt little boy.

We battled the cold and the winds of the night,
and have left that warm steak that was cooked up just right.

The voice of our boss rings so fresh in our minds,
when so often we are late as he too quickly finds.

There's the shrill of your spouse as you run to a call,
cause the mower's still running and the kids must play ball...

But despite all the bad things we can grasp from our mind,
the satisfaction of helping others is still one of a kind.

It's just sort of a force we can't hold in our hand,
but when you feel it and live it, folks just strike up the band...

It's that wonderful feeling deep down in your heart,
when you help save a life by just doing your part.

We all work and train hard and we've built quite a team,
just visit our station and you'll see our pride gleam.

Hand in hand we all work in this EMS field,
in our hearts a great caring to which we can't seem to yield.

EMS volunteers please hold your heads high,
you're so helping and loving, that's a great reason why.

In the face of our loss we are sad as you know,
but emergencies still happen, and ambulances must still go.

Though our hearts are half empty and the mood remains sad,
a life full of helping others leaves us all happy and glad.

Larry A. Mabe

DC-MD Memorandum of Understanding

A memorandum of understanding was signed between Maryland and the District of Columbia regarding prehospital care and the delivery of trauma patients. Governor Harry Hughes and Mayor Marion Barry signed the memorandum in two ceremonies, one held at Prince Georges General Hospital and Medical Center (PGGHMC) in Cheverly, Maryland, and the other at the Children's Hospital National Medical Center in Washington, DC. The ceremony was attended by congressmen, state senators, delegates, the Prince Georges county executive, representatives from various agencies, and medical personnel from the District and Maryland.

The memorandum was to "formalize what we have been doing right along," says Willie C. Blair, MD, director of trauma at PGGHMC, and a "graduate" of the MIEMSS fellowship program. "This is cooperation between two sovereignties to deliver quality care for the injured patient. We know no boundaries when it comes to dispensing quality care, but sometimes questions arise when emergencies occur close to jurisdictional boundaries—should DC residents be taken to Maryland hospitals, or the reverse. This document gives us guidelines."

The document states that "in those trauma cases where time is essential to adequate health care, or where local facilities are unable to accept the patient, or where mechanical condition of the transport unit, traffic, or weather conditions dictate, the patient shall be taken to the nearest trauma facility regardless of jurisdiction. Each jurisdiction shall identify the trauma facility or facilities that other jurisdictions should access.

"In other cases, trauma victims in Maryland or the District of Columbia shall be transported to trauma facilities within the jurisdiction where the accident occurred."

The adult trauma centers that other jurisdictions should access as designated in this agreement are the following:

In Washington: DC General Hospital, Howard University Hospital, George Washington University Medical Center, Georgetown University Medical Center, and Washington Hospital Center (MEDStar). The primary DC adult trauma center receiving patients by helicopter is Washington Hospital Center (MEDStar).

In Maryland: Francis Scott Key Medical Center, Johns Hopkins Hospital, Peninsula General Hospital and Medical Center, Prince Georges General Hospital and Medical Center, Sinai Hospital of Baltimore, Suburban Hospital of Bethesda, Memorial Hospital of Cumberland, University of Maryland Hospital, and Washington County Hospital.

MIEMSS will continue its current practice of using specialty care centers in the District of Columbia in the areas of pediatric trauma, adult burns, neonatal care, and adult eye trauma. Centers used to provide care in these specialized areas are: Children's Hospital National Medical Center (pediatric trauma), Washington Hospital Center (burns), Georgetown University Medical Center (eye trauma), and Children's Hospital National Medical Center (neonatal care).

The District of Columbia EMS system will access the following Maryland specialty referral centers as required: Johns Hopkins Hospital Pediatric Trauma Center; Baltimore Regional Burn Center, Francis Scott Key Medical Center; Maryland Eye Trauma System, Wilmer Institute Trauma Center, Johns Hopkins Hospital; Maryland Regional Neonatal Program (primary: Francis Scott Key Medical Center, Johns Hopkins Hospital, University of Maryland Hospital; secondary: Mercy Hospital, Saint Agnes Hospital, Sinai Hospital, and Greater Baltimore Medical Center); High Risk Perinatal Program, Johns Hopkins Hospital and University of Maryland Hospital; Hyperbaric Medicine Center, Shock Trauma Center, University of Maryland Hospital; Neurotrauma Center, Shock Trauma Center, University of Maryland Hospital; Raymond M. Curtis Hand Center, Union Memorial Hospital; Shock Trauma Center, University of Maryland Hospital; emergency cardiac surgery centers at Johns Hopkins Hospital and University of Maryland Hospital; cardiac consultation centers at Francis Scott Key Medical Center, Johns Hopkins Hospital, and University of Maryland Hospital; and the Maryland Poison Center, University of Maryland at Baltimore.

A committee was established with representatives from each jurisdiction to monitor the agreement, report violations to the respective EMS agency, and develop and monitor triage treatment protocols consistent with the agreement. There are five members from each jurisdiction on the committee, and the chairmanship will rotate.

Financial agreements were also negotiated. The Medical Care Program of the Maryland Department of Health and Mental Hygiene will waive the current day limit for patients admitted to trauma, burn, and neonatal specialty referral centers in Washington, DC; and when a District of Columbia Medicaid patient is admitted to a Maryland facility for trauma, the DC Medicaid Program will reimburse the Maryland facility in accordance with rates established by the Maryland Health Services Cost Review Commission.

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MIEMSS Director R Adams Cowley, MD, Maryland's Governor Harry Hughes, and DC's Mayor Marion Barry sign a memorandum of understanding.

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Teamwork Battles Hurricane Gloria

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brought two engines from Station 600 in Berlin, and one engine came from Station 900 in Bishopville. One of the Berlin engines was later sent to the fire at 12th Street. A small electrical fire was extinguished in a small two-story structure at 10th Street and the boardwalk. At 49th Street, two units were needed to extinguish a structural fire. Pumpers #701 and #704 were on the scene in waist-deep water. OCVFC President Steve Hale, who was on the scene, says that the ambulance never made it because the engine was flooded by salt water 1½ blocks away. Although the firefighters at these fires worked shorthanded, they worked well together. Capt. Price says, "It was a job well done."

At 9 am Friday, the Maryland National Guard entered Ocean City to aid in search and rescue and to prevent looting of damaged homes and businesses.

By 10 am all OCVFC units returned to headquarters. At 10:40 the mayor and city council issued an advisory stating: "Ocean City has survived." Priorities in getting the town back to normal included putting the phone system back in service; clearing the streets and sidewalks of debris; activating damage assessment procedures; immediately closing the boardwalk from 5th to 27th Street; permitting residents, property owners, and media to return to town; and lifting the ban on the sale of alcoholic beverages.

There was a good deal of damage done to the fire company's emergency equipment: The tower truck had about $5,000 damage. There were 14 fire apparatus in which the wheels had to be pulled and the bearings repacked; 5 vehicles with Allison transmissions had to be emptied of salt water. There were at least 17 flat tires, which kept happening over 2 or 3 days. In all, there were about $15,000 of mechanical repairs needed on fire apparatus. Small equipment, such as hand lights, nozzles, air packs, pagers, walkie-talkies, axes, and boat cutters, were either lost or damaged due to the high winds and water. "If we put them down for a minute they were gone," Chief Steger says.

Steve Hale says, "All the volunteers went above and beyond the call of duty. Their first priority had to be to secure their families; their second was to protect their neighbors and the citizens of the community."

"We received outstanding cooperation from our neighbors in Berlin and Bishopville; the mayor, city council, and city manager; the Coast Guard; and all the local utilities and state agencies," Chief Steger says. "A good working relationship with neighbors makes all the difference in such an emergency."

—Erna Segal

DC-MD Agreement

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"The idea for the agreement has been around for a long, long time, because we were having problems between the two 'states' and trying to solve them," says R Adams Cowley, MD, director of MIEMSS. "Some people thought we should designate one hospital to be a receiving area or deal with hospitals directly, but we can't show partiality."

The memorandum of understanding was signed for the District of Columbia by Mayor Marion Barry; Reed V. Tuckson, MD, acting commissioner of public health; and Mary J. Berkely, executive director of EMS. Maryland signers were Governor Harry Hughes; Thomas A. Farrington, chairman of the governor's negotiating team; and Dr. Cowley.

—Erna Segal