DIVISION OF EMERGENCY MEDICAL SERVICES
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
22 S. GREENE STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 528-6846

Neil Solomon, M.D., Ph.D., Secretary

April 2, 1975

DIVISION OF EMERGENCY MEDICAL SERVICES POLICY
REGARDING SPECIALTY REFERRAL CENTERS AND THE STATE POLICE AIR MED-EVAC

A Maryland Emergency Medical Services System has been established to assure every citizen the right to the best emergency medical care that science can provide, regardless of the type of illness or injury, its severity, the citizen's personal circumstances or his geographical location. If you determine that a patient needs immediate life-saving therapy in a special medical center, the Maryland Emergency Medical Services System is available to you. The system includes communication to expedite all decisions and transportation arrangements, rapid transportation by Med-Evac helicopters if required, and designated Specialty Referral Centers in which the best of specialized care is available to handle your patient's problem.

A telephone call to SYSCOM , the System Communication Center at the Maryland Institute for Emergency Medicine, is all that is required for you to utilize the system. The SYSCOM personnel will coordinate your request with the proper Specialty Referral Center and the Maryland State Police Med-Evac helicopter. The system is designed to insure that your patient will receive the best medical treatment available to complement your private practice or your hospital emergency room.

The Maryland State Police have four Bell-Jet Ranger type helicopters in service and available for regular Med-Evac and law enforcement missions. By this summer, two larger Sikorsky helicopters will have been outfitted for use as back-up aircraft for large scale disaster and special mission use. The Bell-Jet Rangers are located in the Frederick, Greater Baltimore, and Washington areas. The purpose of this service is to transfer acute critically ill and injured patients to the State's Specialty Referral Centers, whenever this mode of transportation would be the most rapid and efficacious, either from the scene of an accident

or from other hospitals requesting a patient transfer to one of the Specialty Referral Centers listed below:

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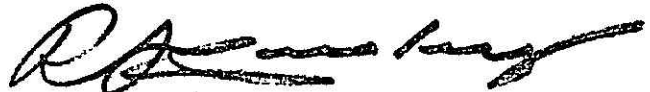
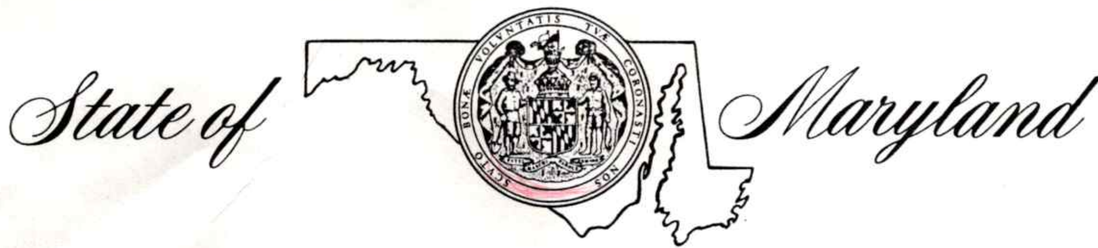


R Adams Cowley, M. D.
Director, Emergency
Medical Services

CURRENT TELEPHONE NUMBERS
EMS SYSTEMS CONTROL CENTER

| | |
|---|---|
| In-bound WATS line - Statewide | (Toll Free) 800-492-0610 |
| Regular phone lines | 528-7813 |
| Maryland State centrex line | 383-3268 |

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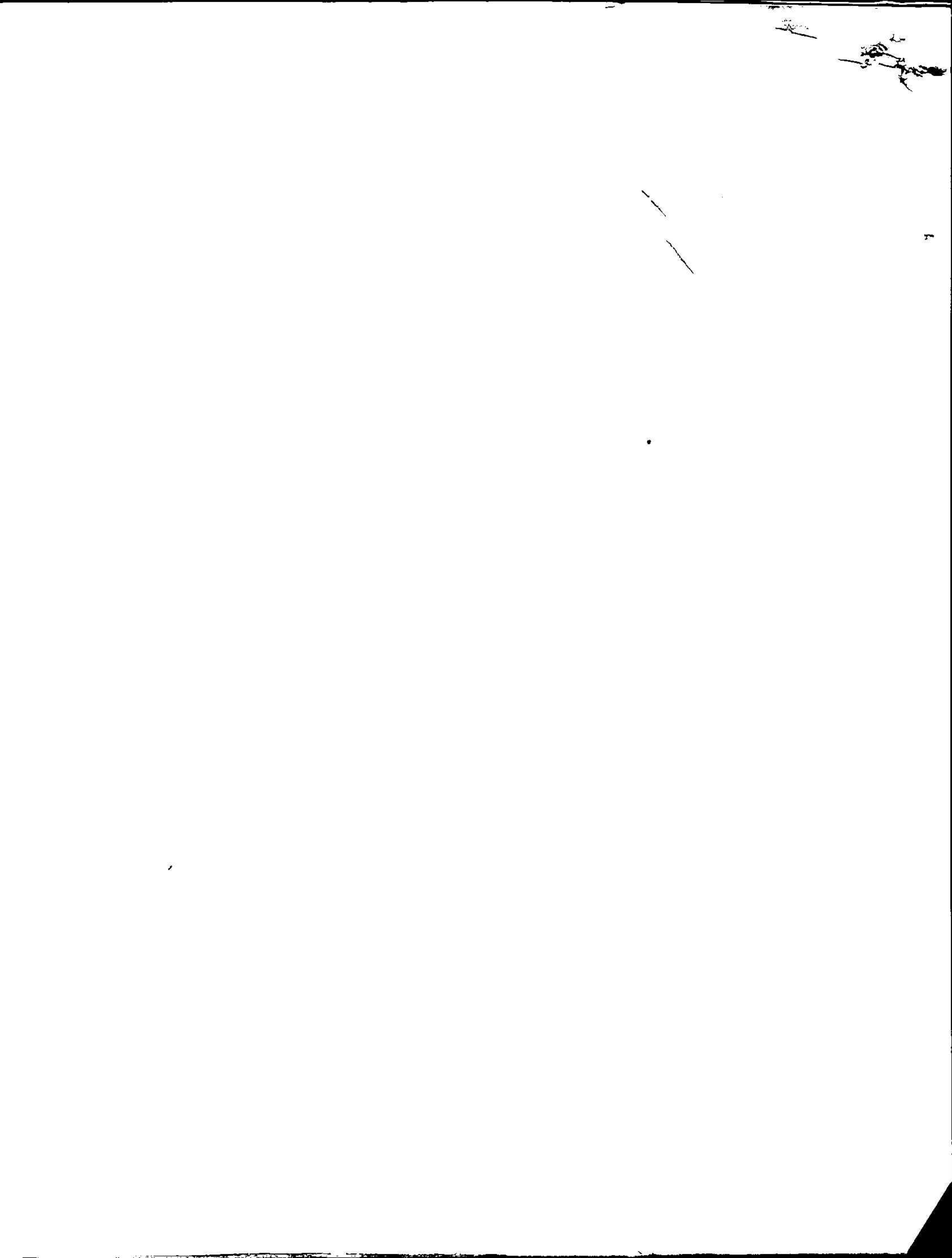

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# MARYLAND STATE POLICE HELICOPTER OPERATIONS

*by the Aviation Div., Maryland State Police*

The Maryland State Police Aviation Division operates a fleet of Bell 206B Jet Ranger five passenger (two litter patient) helicopters throughout the state. These helicopters have a range of 400 miles with speeds up to 140 MPH. Their basic mission is to provide aerial support to ground patrol units in both traffic safety and crime suppression activities. However, one of the most important functions of these aircraft is the evacuation of desperately ill or critically injured persons from accident scenes to specialty referral centers. The central control point for these centers is the Maryland Institute for Emergency Medicine (formerly the University of Maryland Center for the Study of Trauma) and was created under the Emergency Medical Services System by Governor Marvin Mandel in 1973. This institute is where the majority of all adult patients transported by our Med-Evac helicopters are taken. Here each patient is afforded the most advanced innovative medical procedures designed to keep the patient alive and reduce permanent injury to the body.

## CREWS AND EQUIPMENT

Each of the helicopters has a crew consisting of a Maryland State Police pilot and an EMT-certified Maryland State Police observer/medic. The observer/medic's duties are to coordinate the missions of the helicopters and to, most importantly, care for the patient once the Med-Evac transport has been initiated. Each helicopter is equipped with basic first aid supplies, oxygen bottle, Laerdal suction unit, cardiac monitor beeper, etc. Each of the helicopters are equipped with State Police FM type radios and a portable radio that is used to talk on the fire departments' mutual aid frequency. The helicopters also carry a 3.9 million candlepower searchlight that can illuminate a large area.

## LOCATIONS AND FLIGHT REQUESTS

The helicopters are strategically located throughout the state at Martins Field outside of Baltimore, Andrews Air Force Base in Prince George's County and at the Frederick Airport. A thirty mile radius from an operational base is the primary response zone for each helicopter. A total of seven helicopters are eventually planned to give the entire state this type of complete coverage. Requesting the service of a helicopter is simple. Contact the closest Maryland State Police barrack or installation. For routine requests or matters in which time is not of the essence, the number to call for the Aviation Division office in Pikesville is 486-3101, extension 235 or 236, or 486-8446.

## MISSIONS

Helicopters are dispatched according to their need and top priority is given to life-saving missions. The helicopters also participate in inter-hospital transports of critically ill or injured patients at the direction of the Maryland Institute for Emergency Medicine. The aircraft transport premature and neonatal babies from outlying hospitals to the City Hospitals Regional Intensive Care Nursery Unit. Seriously burned patients are transported to the City Hospitals Intensive Care Burn Unit. Traffic patrol, criminal searches, search and rescue missions for lost or missing persons, fire fighting liaison and surveillance are just a few of the other missions performed by the helicopter crews.

## WEATHER RESTRICTIONS

Generally speaking, the helicopters fly in most types of weather. However, thunderstorms, heavy snow, hail storms, thick fog and severe high winds preclude safe flight and the helicopters may be delayed. The flight minimums established for the helicopters are guided by FAA regulations and are based on VFR (visual flight rules). The minimums are:

Daytime flights—600 feet AGL (above ground level) with one (1) mile forward visibility

Nighttime flights—800 feet AGL with two (2) miles visibility

FIGURE 1.

(Over)

## LANDING AREAS

Safety requirements for helicopter landings is primary for the completion of our missions. Ground personnel, whether policemen or firemen, who have radio contact with the helicopter must advise the crew of the most desirable landing zone nearest the scene. Ground personnel must check the entire landing zone for obstructions or obstacles such as trees, poles, ditches, signs, wires, etc., and advise the helicopter crew of these obstacles prior to the landing. Although a helicopter can hover straight up and down, this type of landing is the most dangerous configuration for the aircraft. A helicopter landing or take-off can be accomplished safer if it can be done similar to fixed wing aircraft, i.e. coming down at a slight angle to the ground while maintaining forward airspeed up to the touch down site.

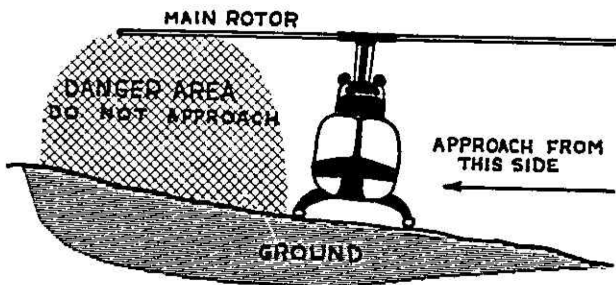


FIGURE 2.

Daytime landing zone requirements are relatively simple. Attempt to set up the largest open unobstructed landing zone possible such as a farm field, parking lot, dual lane boulevard or median strip.

Nighttime landings require that the border of the zone be marked by lighted flares. A circle or square pattern of at least 50-60 feet minimum is desired. Four to six flares are required. A crisscross or "X" type flare arrangement is not recommended. Flood or spot lights should not be aimed up at the landing helicopter, but should illuminate the ground of the landing site.

## ASSISTANCE REQUIRED TO LOAD MED-EVAC PATIENT

The observer will need assistance at the transport pickup scene with securing the patient on the litter, carrying him to the aircraft and loading the patient aboard. Firemen, policemen or civilians are utilized for this purpose. At the observers instruction, the person assisting will take a position at the bottom

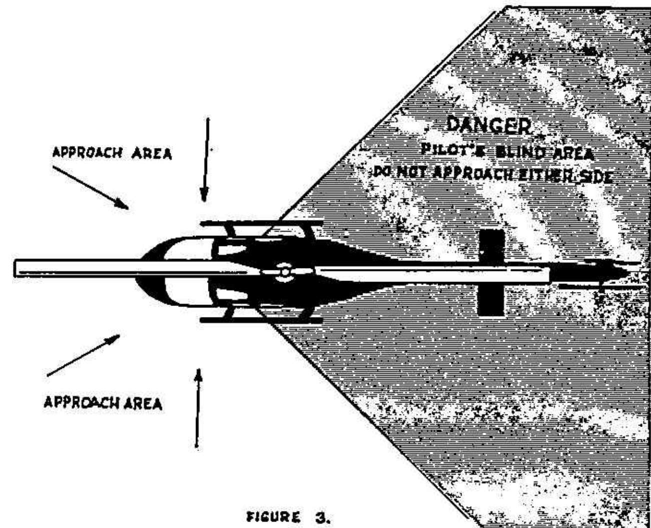


FIGURE 3.

of the litter near the feet of the patient and assist in carrying the litter to the helicopter. The assistant will be instructed to place his end of the litter in the forward part of the aircraft first, with the observer guiding the head or top portion of the litter into the ship and securing it in place. The job of the assistant is then completed and he is instructed to back safely away from the aircraft.

FIGURE 4.

## INTER-AGENCY COOPERATION

The Maryland "Med-Evac" program came into existence in 1969 and has transported since then over 2,500 patients. The survival rate for these patients, most of whom suffered major trauma injuries, is approximately 83%. The primary reason attributed to such a high survival rate has been getting the patient to a properly staffed and equipped treatment center in the shortest possible time. The Maryland system continues to demonstrate that many lives can be saved when fire departments, ambulance and rescue squads, police personnel and hospital personnel work together for the good of the patient.

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April 2, 1975

Dear Doctor:

Enclosed is a copy of the Division of Emergency Medical Services policy as it relates to Specialty Referral Centers and the State Police helicopter system.

This policy explains the system and how to utilize the system should you wish to do so.

Sincerely yours,

R Adams Cowley, M.D.
Director, Emergency
Medical Services

RAC/sb

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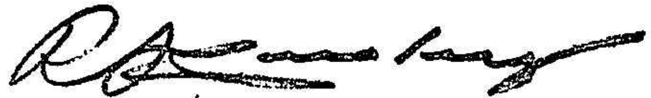

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SHOCK TRAUMA CENTER
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OPERATIONS RESEARCH/
SYSTEMS MANAGEMENT

March 28, 1975

MEMORANDUM

TO: Dr. Gill, Dr. McAslan, Dr. Austin, Dr. Champion, Miss Scanlan, Dr. Long, Mr. Garrett, Mr. Hathaway, Nurse Chairmen, Administrators, Team Leaders, Clerks, Dispatchers

FROM: R Adams Cowley, M.D.

For your information and review, attached is a policy statement on the use of the air med-evac helicopters.

To clarify this policy and receive your input before a copy is distributed outside the Institute there will be two meetings held on Monday, March 31st at 8 a.m. and 4 p.m. in Room 2-909 to discuss this policy.

Attendance is mandatory at one of these meetings.

Jean Cosby
John Morris

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Jean Cosby:
whose job is it to call ~~when dispatcher~~ ~~calls~~ the team leader?

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University of Maryland Hospital

Whenever possible, helicopter transportation will be provided for emergency critically ill and injured patients who, because of their life-threatening problems, demand intensive multidisciplinary treatment and care. Adult patients with severe multiple injuries, head trauma, overwhelming septicemia, refractory shock, gas gangrene infections, scuba diving accidents or other entities deemed life threatening by the physician are taken to the Maryland Institute for Emergency Medicine. Children under the age of 14 with injuries listed above are taken to the Johns Hopkins Pediatric Trauma Center. When an adult and child from the same

family are involved, both are taken to the Maryland Institute for Emergency Medicine. Patients with burns are taken to the Baltimore City Hospitals Burn Center. Newborns are taken to the Premature Nurseries at either the University of Maryland Hospital or the Baltimore City Hospitals. Should these resources be unavailable because of inadequate bed space at the time of the mission, it is the responsibility of the System Communication Center (SYSCOM) to make arrangements for that patient to be transferred to the nearest hospital with the most appropriate specialized capability for handling the problem.

If transportation to a Specialty Referral Center is requested, a senior MIEM physician is always available through SYSCOM to consult with the physician requesting the transportation. The requesting physician will, it turn, be immediately notified by a SYSCOM dispatcher as to the availability of the helicopter, availability of beds, time of arrival, etc., and every effort will be made to expedite the mission.

This program is NOT designed to handle patient transfers to individual physicians or institutions other than the Specialty Referral Centers providing an around-the-clock service nor is it designed to provide shuttle service between hospitals. To do this would require a far larger fleet of helicopters than exists at present. Similarly, it is impractical to allow any physician in the State to summon a helicopter directly - this rapidly saturates the system and renders it ineffective. With the limited number of aircraft in the system, central coordination is a necessity.

The policy described above has been in effect through the formative years of Maryland's Emergency Medical Services System. Also noted above are present Specialty Referral Centers of the system. This policy is subject to continuous review by the Division of Emergency Medical Services and its volunteer advisory committees including the Regional Emergency Medical Services Council and the Medical Management Consultant Group as well as by the Maryland State Police. These agencies also are undertaking a review to identify and establish additional Specialty Referral Centers to handle other life-threatening situations such as psychiatric, alcohol and drug overdose, and cardiac emergencies.

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5/28/75

**Hospital Transfer Pleas Rejected**

# Md. Unit Limits Copter Use

By B. D. Colen
Washington Post Staff Writer

Officials of the Maryland Institute for Emergency Medicine (the shock trauma unit) in Baltimore have, as a matter of policy, been refusing the use of the state's from Medevac helicopters to doctors wishing to transfer patients between hospitals.

Doctors at Howard County General Hospital in Columbia have requested such inter-hospital transfers twice since Feb. 11. Both times the requests were denied. Both times the patients died.

Dr. Thoburn A. Dadisman, chief of medicine at Howard General, said it is impossible to tell if the patients would have lived, had they been transferred. "Nobody can answer that," said Dadisman, who personally made the request on Feb. 11.

Shock trauma officials justified their actions by saying the medical uses of the helicopter must be carefully limited or the Medevac service will turn into a medical taxi service.

Dr. Dadisman said he called the shock trauma unit and requested a helicopter shuttle for a 17-year-old heart patient who "was in congestive heart failure."

Dadisman asked that the youth be taken to the John Hopkins cardiac unit, because "I'm not on the staff of University Hospital (where the shock trauma unit is located) and don't know the cardiologists there, so I referred to Hopkins where I do have privileges and do know the staff."

The second incident occurred on March 5, when another doctor at Howard General asked that a patient who was bleeding to death be transfered to the main unit of University Hospital for immediate surgery. That request, like Dadisman's, was refused.

In both cases, the patient's were eventually transferred to the preferred hospitals by an Army helicopter provided by Ft. Meade. Both patients died within hours of their transfer.

According to Dr. William Gill, clinical director of the shock trauma unit, both patients were offered admission to the unit, or certainly would have been granted it had it been requested.

"Both patients could have been adequately handled (at shock trauma)," said Gill. "That's the definition of our purpose to handle all life threatening critical injuries and illness."

The use of the four helicopters is controlled by the State Police, but all medical use of the machine is funneled through and controlled by the shock trauma unit. The unit only allows transfer of patients to shock trauma, the burn and infant intensive care units at Baltimore City Hospital and the infant intensive care and pediatric shock trauma unit at John Hopkins Hospital.

If exceptions to the policy are made on a large scale, he said, the Medevac helicopters will become nothing but a medical taxi service.

When asked how transportation could be denied to a dying patient, when the helicopters have been used by the State Police 469 times since 1970 to ferry state government officials, Dr. Gill said any reply would be a "purely personal comment," and refused to elaborate.

The shock trauma unit has nothing to do with the non-medical woes of the helicopters.