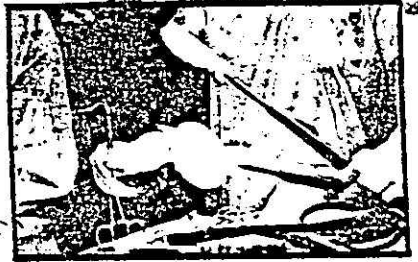
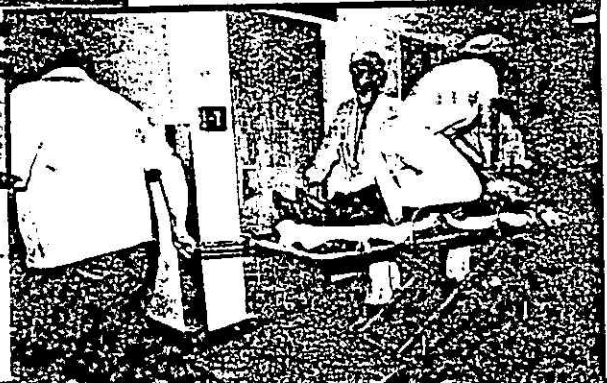


THE



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M*A*S*H—Baltimore-Style

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His complaint is interrupted by the police radio, breaking out in a loud crackle of static. Dr. Shatney leans for-

Photographs by David Esposito



SHOCK FIGHTERS

By William Barnhill

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continued on page 16

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continued on page 18

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16 FAMILY HEALTH

THE SHOCK FIGHTERS

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All this makes MIEMSS—what Dr. Boyd calls "the Taj Mahal of shock trauma units"—a virtually unique phenomenon. These marvels of men and machines cost money—big money. The Baltimore Center, with only 54 beds, needs an annual operating budget of 9.8 million dollars—not including the cost of the helicopter services, which is picked up by the Maryland State Police, nor the cost of the many ambulances that also deliver patients to its doors. Even after most of the costs have been recovered from insurance companies, welfare agencies and patients, the center still has to turn to the State of Maryland to make up a 1.9 million dollar deficit.

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But that investment has not been made. As a result, the nation's rural areas, which account for 80 percent of our yearly auto deaths, must continue to rely on emergency-room services.

Is that really so bad? After all, emergency-room medicine has made great strides during the last seven years. Congress has pumped 21.4 million dollars into the states in an effort to bring America's 5,000 emergency rooms into the 20th century. Another 20.1 million dollars will be spent this year, and probably a like amount in 1982.

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The anesthesiologist, Peter Margand, MD, checks his watch. He and a nurse peel off from the huddle and climb into a waiting ambulance. It carries them two blocks to the helipad, still deserted and silent. There they wait, peering intently into the darkness for the first sign of the State Police Med-Evac helicopter.

1:41 A.M. The ambulance attendant, a new man, fidgets nervously with his equipment. But Dr. Margand and the nurse are relaxed and ready; they've been through this countless times before. Their job is to steal an extra few minutes for the patient. Until now, he has been in the capable hands of paramedics. They have stanchied the flow of blood and inserted intravenous tubes to replace lost fluids and delay the onset of deep shock.

Out of the darkness, the whumping throb of the helicopter's rotor blades breaks the silence. It pushes heavy gusts of air over Margand and his people as it touches down, landing lights casting an eerie glow over the scene. In moments, the patient is off the chopper, loaded into the ambulance on a wheeled treatment table. Now Margand and the nurse take over. With sirens screaming a warning to other vehicles, the ambulance races down the ramps of the seven-story garage to the rear entrance of the shock trauma center.

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three minutes after the chopper touched down, they are in admitting. The patient has been shrieking all the way.

He is a good-looking boy, or he was, earlier tonight. Now, his face and head are covered with dirt and blood. He is bleeding copiously from a dozen wounds, blood pooling on the floor beneath the treatment table.

Astonishingly, he is still conscious, but he does not know where he is. His hands flutter weakly on the table as he tries to ward off the nurses. What's left of his clothing is quickly cut off him and tossed to one side as the trauma team converges on him, seemingly oblivious to his cries.

"Oh, my God," he screams. "What are you doing to me? Don't do that, leave me alone. Oh, God, it hurts!"

1:46 A.M. Margand has now inched a tube down the boy's throat into his lungs; from now on a machine will breathe for him. The human body uses up 18 percent of its available energy just breathing; this boy hasn't got 18 percent to spare.

Blair, the other surgeons and the nurses are all examining the boy, cleansing his wounds and dousing him with iodine from plastic gallon containers, which are tossed aside when emptied. Shatney serves as overseer, murmuring encouragement, providing advice. He is sure that the boy has internal injuries, but he must have confirmation before he goes inside.

Now Margand eases a nasogastric tube into the boy's nostril, down into the stomach to suck out the accumulated gas and air that must be released before an incision can be made. Another surgeon is inserting a catheter to empty the patient's bladder, further preparation for surgery.

The neurosurgeon hasn't arrived yet, and until he makes his examination, no pain-killer can be administered. But it is safe, Shatney decides, to insert a tube directly into the boy's stomach through a small incision, using a local anesthetic. Deftly, Blair makes the cut, inserts the tube, and fastens it with a few stitches. It doesn't hurt, but the terrified, bewildered patient knows *something* is happening. As his screams grow ever more strident, a tall, thin nurse patiently swabs the blood off his face, out of his eyes, while maintaining a steady stream of encouragement. "It's all right, baby," she murmurs softly. "You're going to be all right. Just don't worry now, everything is going to be fine."

M*A*S*H—Baltimore-Style

Continued from page 18

1:15 A.M. It's less than ten minutes since the helicopter touched down. The neurosurgeon, Paulo Molterro, MD, has arrived and is rapidly checking the boy. There are no head or spinal injuries, he says; it's safe, finally, to relieve his agony. Seconds after he's given an injection, the boy's screams begin to taper off. Soon he's quiet.

But the stomach tube has confirmed Shatney's suspicion of internal injuries by releasing a flow of bright red blood. Shatney will be going 'inside soon. He does not yet know if his job will be to repair damage, or remove hopelessly torn organs—or both.

2:17 A.M. The patient is ready for x-rays, more lab tests and preparation for surgery. Several members of the team have slipped away quietly. At one point, there were 14 people working over this boy simultaneously, some of them jammed sideways around the six-foot treatment table. Now there are only five. The others have moved to another of admitting's four treatment cubicles, because a new patient has arrived. Now Shatney joins them, and this time he cannot help grimacing as he sees what is waiting for him.

This one—a man apparently in his 20s—was in a motorcycle accident. He is one of those who chose to exercise his "right" to drive a 750-pound motorcycle without the protection of a helmet. When these riders pile up, they seldom survive. The team goes to work, but this time there are no miracles.

3:34 A.M. The motorcycle victim has been pronounced dead. By then the team has split up again, because yet another patient has arrived, transferred from a community hospital emergency room that couldn't handle him. The diagnosis: spinal cord injury.

6:30 A.M. Both living patients have been stabilized. Fluids are being pumped into them, to ready them for the additional shock of surgery.

For a moment, some members of the

trauma team collapse into chairs, lands still for the first time in hours. While they were in action, they joked, they laughed, they chattered about trivialities, their emotions held in check as they raced against time for the prize of a life. Now their masks briefly drop.

Shatney, too, takes a well-earned break. He sits quietly, feet propped up on a chair, sipping coffee, his face drawn and tired. It's not the work that has worn him down most on this rough night: It's the fact that one out of three patients he has treated in the last two hours didn't make it. "He only had about a two percent chance when he came in," Shatney mutters. But his eyes tell a different story: He's lost one—and he cares.

9:10 A.M. Both patients are out of surgery. The two boys will now spend many weeks in the center's 12-bed critical care recovery unit, staffed by eight to ten nurses who use some of the most sophisticated medical equipment in the world. Each patient will be plugged into a computer that monitors blood pressure, temperature, pulse rate and respiration, spewing out minute-by-minute readings on a bedside screen. Other equipment will automatically check them for infection, keep track of their cardiac output, pulmonary function, even pressures in the brain. Each time one of the boys takes a breath, a mass spectrometer will analyze that breath.

Shatney has accompanied them to the recovery unit, not only to oversee their admission, but to make his usual morning rounds. He will be at this for another two hours.

11:30 A.M. Shatney trudges out of the center, finally heading home. He's been on his feet now for 28 hours. He still hasn't had that sausage sandwich.

As the doors swing closed behind him, the police radio comes to life again, and the new trauma team that has taken over gathers to listen. "Syscom, this is County Seventeen. We have an admission in ten minutes; ten minutes to ETA." ■

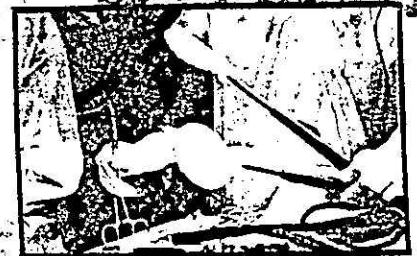
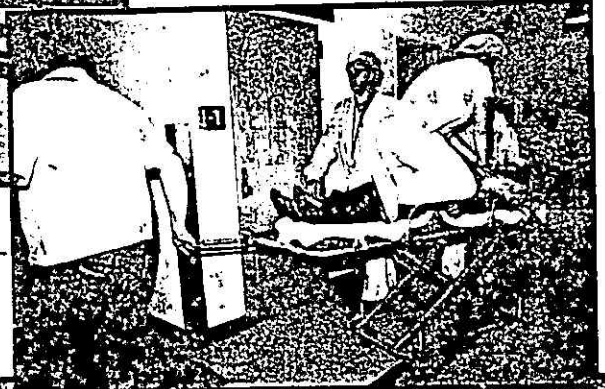
—W.B.



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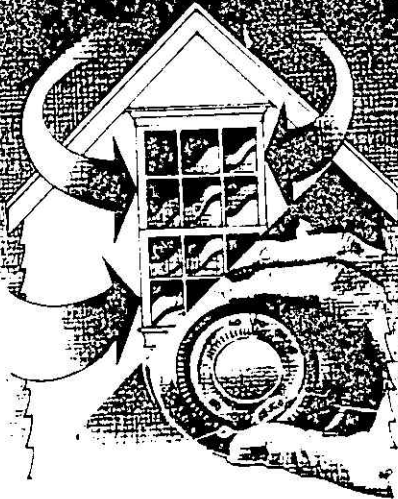
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He is a good-looking boy, or he was, earlier tonight. Now, his face and head are covered with dirt and blood. He is bleeding copiously from a dozen wounds, blood pooling on the floor beneath the treatment table.

Astonishingly, he is still conscious, but he does not know where he is. His hands flutter weakly on the table as he tries to ward off the nurses. What's left of his clothing is quickly cut off him and tossed to one side as the trauma team converges on him, seemingly oblivious to his cries.

"Oh, my God," he screams. "What are you doing to me? Don't do that, leave me alone. Oh, God, it hurts!"

1:46 A.M. Margand has now inched a tube down the boy's throat into his lungs; from now on a machine will breathe for him. The human body uses up 18 percent of its available energy just breathing; this boy hasn't got 18 percent to spare.

Blair, the other surgeons and the nurses are all examining the boy, cleansing his wounds and dousing him with iodine from plastic gallon containers, which are tossed aside when emptied. Shatney serves as overseer, murmuring encouragement, providing advice. He is sure that the boy has internal injuries, but he must have confirmation before he goes inside.

Now Margand eases a nasogastric tube into the boy's nostril, down into the stomach to suck out the accumulated gas and air that must be released before an incision can be made. Another surgeon is inserting a catheter to empty the patient's bladder, further preparation for surgery.

The neurosurgeon hasn't arrived yet, and until he makes his examination, no pain-killer can be administered. But it is safe, Shatney decides, to insert a tube directly into the boy's stomach through a small incision, using a local anesthetic. Deftly, Blair makes the cut, inserts the tube, and fastens it with a few stitches. It doesn't hurt, but the terrified, bewildered patient knows *something* is happening. As his screams grow ever more strident, a tall, thin nurse patiently swabs the blood off his face, out of his eyes, while maintaining a steady stream of encouragement. "It's all right, baby," she murmurs softly. "You're going to be all right. Just don't worry now, everything is going to be fine."

M*A*S*H—Baltimore-Style

continued from page 18

1:45 A.M. It's less than ten minutes since the helicopter touched down. The neurosurgeon, Paulo Molterro, MD, has arrived and is rapidly checking the boy. There are no head or spinal injuries, he says; it's safe, finally, to relieve his agony. Seconds after he's given an injection, the boy's screams begin to taper off. Soon he's quiet.

But the stomach tube has confirmed Shatney's suspicion of internal injuries by releasing a flow of bright red blood. Shatney will be going inside soon. He does not yet know if his job will be to repair damage, or remove hopelessly torn organs—or both.

2:17 A.M. The patient is ready for x-rays, more lab tests and preparation for surgery. Several members of the team have slipped away quietly. At one point, there were 14 people working over this boy simultaneously, some of them jammed sideways around the six-foot treatment table. Now there are only five. The others have moved to another of admitting's four treatment cubicles, because a new patient has arrived. Now Shatney joins them, and this time he cannot help grimacing as he sees what is waiting for him.

This one—a man apparently in his 20s—was in a motorcycle accident. He is one of those who chose to exercise his "right" to drive a 750-pound motorcycle without the protection of a helmet. When these riders pile up, they seldom survive. The team goes to work, but this time there are no miracles.

3:34 A.M. The motorcycle victim has been pronounced dead. By then the team has split up again, because yet another patient has arrived, transferred from a community hospital emergency room that couldn't handle him. The diagnosis: spinal cord injury.

6:30 A.M. Both living patients have been stabilized. Fluids are being pumped into them, to ready them for the additional shock of surgery.

For a moment, some members of the

trauma team collapse into chairs, lands still for the first time in hours. While they were in action, they joked, they laughed, they chattered about trivialities, their emotions held in check as they raced against time for the prize of a life. Now their masks briefly drop.

Shatney, too, takes a well-earned break. He sits quietly, feet propped up on a chair, sipping coffee, his face drawn and tired. It's not the work that has worn him down most on this rough night: It's the fact that one out of three patients he has treated in the last two hours didn't make it. "He only had about a two percent chance when he came in," Shatney mutters. But his eyes tell a different story: He's lost one—and he cares.

9:10 A.M. Both patients are out of surgery. The two boys will now spend many weeks in the center's 12-bed critical care recovery unit, staffed by eight to ten nurses who use some of the most sophisticated medical equipment in the world. Each patient will be plugged into a computer that monitors blood pressure, temperature, pulse rate and respiration, spewing out minute-by-minute readings on a bedside screen. Other equipment will automatically check them for infection, keep track of their cardiac output, pulmonary function, even pressures in the brain. Each time one of the boys takes a breath, a mass spectrometer will analyze that breath.

Shatney has accompanied them to the recovery unit, not only to oversee their admission, but to make his usual morning rounds. He will be at this for another two hours.

11:30 A.M. Shatney trudges out of the center, finally heading home. He's been on his feet now for 28 hours. He still hasn't had that sausage sandwich.

As the doors swing closed behind him, the police radio comes to life again, and the new trauma team that has taken over gathers to listen. "Syscom, this is County Seventeen. We have an admission in ten minutes; ten minutes to ETA." ■

—W.B.

