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City Paper

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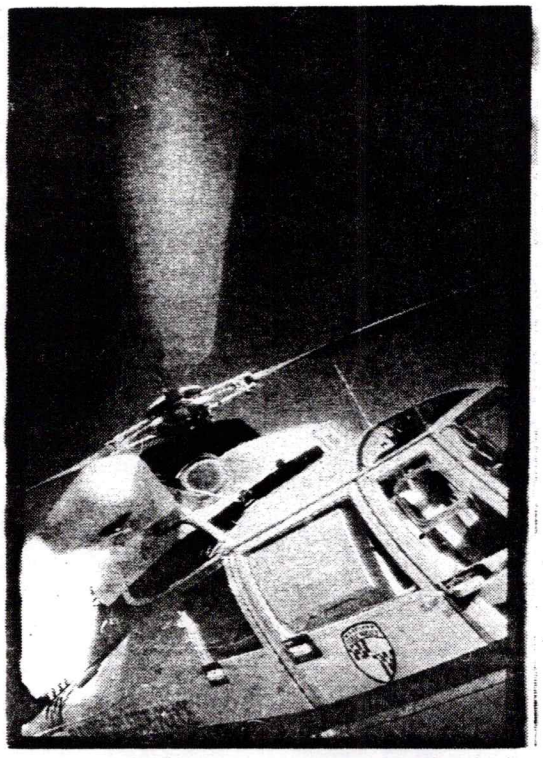
State of SHOCK



With Its Founder Ousted and Its Staff Decimated by Layoffs and Resignations, the Much-Trumpeted Maryland Shock Trauma Center Wrangles with Declining Revenues, Declining Morale, and According to Some Insiders, Declining Quality of Care.

By Alwyn Scott [6]

State of SHOCK

By Alwyn Scott
Cover photo by Mike McGovern
Photos by Joseph Kohl

Six Years After the Maryland Shock Trauma Center Was Privatized, Its Revenues Are Shrinking, Its Staff Is Resigning, and Its Quality of Care Is Being Questioned. So Why Does Everyone Still Think the Place Is So Great?

FROM ITS HUMBLE BEGINNING in 1962 as a two-bed research lab, the Maryland Shock Trauma Center has developed a reputation as one of the finest emergency medical centers in the country—some say the world. Its bright new building at Redwood and Penn Streets is said to be the largest freestanding facility of its kind. It is the hub of a network that enables hundreds of independent hospitals and ambulance companies around the state to deliver accident victims to medical centers swiftly and efficiently. It goes on alert when presidents are injured in Washington, and it stands ready to save the lives of ordinary citizens who might have the misfortune to suffer a massive injury.

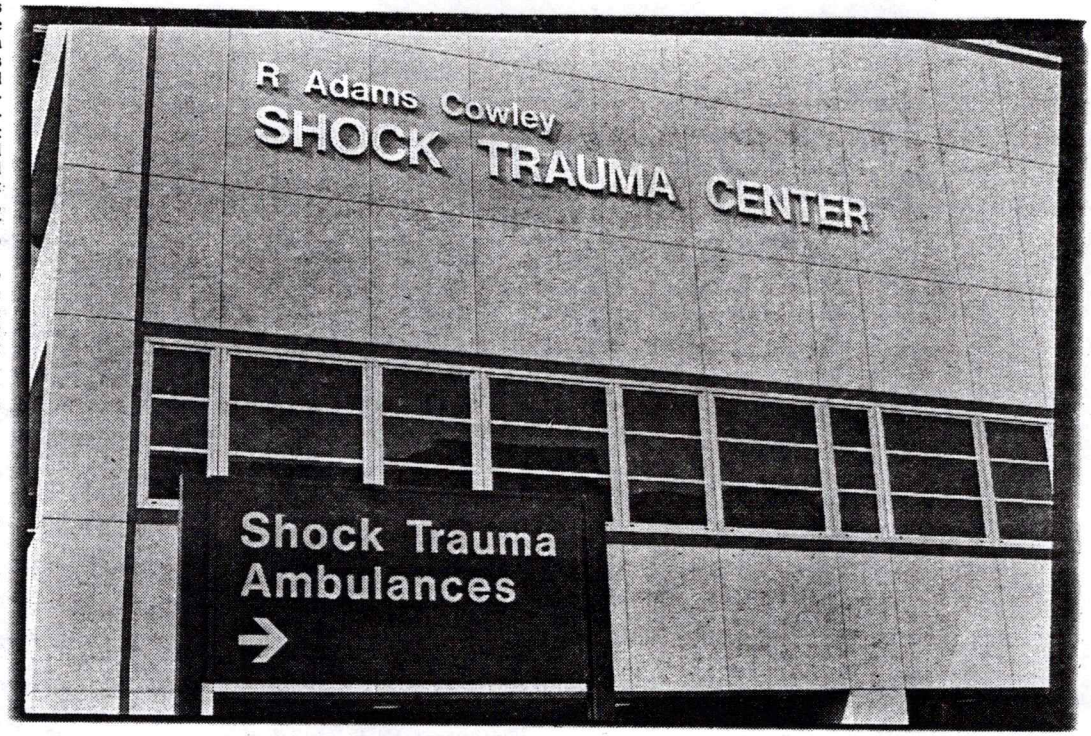
Most Marylanders, however, know it simply by the phrase, "the victim was flown to the Maryland Shock Trauma Center," which shows up almost daily in the Sunpapers during the summer months, when accidents are most frequent. When people think of Shock Trauma, most probably picture an impressive Med-Evac helicopter roaring toward a heliport where people in scrub gear stand by with beds, expertise, and the best medical technology the taxpayers' money can buy.

But that's only part of the picture. What many people don't know is that the state doesn't own or run Shock Trauma anymore. A private corporation, called the University of Maryland Medical System (UMMS), now controls budget, personnel, and policy at the most important trauma hospital in the state. This change in ownership, which occurred six years ago, unleashed numerous changes that many claim have led to a drastic decline in Shock Trauma's morale, its financial health, and the quality of care it provides.

Under UMMS' control, Shock Trauma's founder and director, R Adams Cowley, has been ousted and replaced by an administrator with no trauma experience; its nursing staff has been slashed (47 of 349 full-time positions have been eliminated since 1987, while patient admissions have grown by 11 percent a year); and its ratio of nurses to beds has dropped by 28 percent since 1985. Nurses say they frequently forgo minor medical procedures and family counseling because they don't have time. Doctors contend that in-house rivalries and bickering have hindered—and in some cases prevented—surgery on patients. Morale is reportedly at an all-time low, with nurses quitting at nearly twice the rate of other Maryland hospitals. And for the first time in its 28-year history, Shock Trauma is losing money—a projected $9 million between 1984 and 1990—despite receiving state subsidies of about $3 million a year.

As if these problems weren't enough, Maryland's most prestigious trauma hospital is now facing a takeover threat from the University of Maryland Medical School. A handful of leaders from the school and the hospital have been bargaining bitterly—and in private—over Shock Trauma's fate. The medical school says more academic oversight "will significantly improve the quality of investigation and teaching in the Shock Trauma center." Shock Trauma's doctors, in self-congratulatory style, say the medical school just wants a piece of the most prestigious action on campus, and they have mounted a "save Shock Trauma" campaign that plays on public good will toward the center. In reality, the doctors are fighting for much more: to maintain their positions as private physicians at a state-supported private institution at which they can bill their own patients and control the dispatch of the state's Med-Evac helicopters. They have so much at stake that they've threatened to walk out or resign en masse if the takeover succeeds.

When word leaked out last week that the takeover had been finalized in a closed-door meeting, it touched off a small fire storm. Shock Trauma doctors went on TV bemoaning the deal and predicting that the quality of care at Shock Trauma could be damaged. Others, including Lieutenant Governor Melvin Steinberg, indicated that the matter may not be settled: Steinberg, the governor, or the legislature could still take steps to stop the takeover. But whatever the outcome, it's likely to have a profound effect on the way the center performs.



The reason most often cited for Shock Trauma's current problems is the decision by the state to privatize the center in 1984. Indeed, Cowley's ouster, the budget cuts, low morale, financial losses, and concern about patient care can all be traced to July 1, 1984, the day the state was authorized to transfer ownership of Shock Trauma to a private, non-profit corporation, UMMS. At the same time, UMMS also received title to the University of Maryland Hospital and the University Cancer Center and was charged, according to the law passed by the state legislature, with running all three "at the lowest cost practicable."

Although many observers, including *The Sun*'s editorial writers, backed the privatization plan as a shrewd move that would save the state money and force the three hospitals to become self-supporting, neither expectation has been met. The bill authorizing privatization implied strongly that privatization would cut state spending. "It has proven unnecessarily costly and administratively cumbersome for the university to finance, manage, and carry out the patient care activities of an academic institution within the existing framework of a state agency," the bill said. "It is fiscally desirable for the state of Maryland to separate the operations, revenues, and obligations of the medical system [Shock Trauma, University Hospital, and the University Cancer Center] from the state to the end that, to the maximum extent practicable, the medical system be a self-supporting entity."

Language about fiscal desirability, however, was strikingly absent from the bill's no-nonsense, two-page fiscal note, which predicted a state loss of $4.6 million in hospital investment fund income between fiscal years 1985 and 1989. As for cutting state costs, the fiscal note said, "state expenditures [payroll and administrative costs, for example] are also expected to be reduced under the bill's provisions, although no specific estimate of savings can be provided on the basis of available information." The bill, in other words, created the perception that privatizing the three hospitals would save money without ever bothering to figure out what those savings might be. The bill also said, "The state may make grants" to the corporation "as may be deemed appropriate from time to time." The General Assembly passed the legislation with only two dissenting votes.

Most governments sell companies they want to privatize. But Maryland, in addition to taking the estimated $4.6-million loss in investment income, gave away sizable state assets to make the hospitals private. Between July 1, 1984, and June 30, 1985, the state deeded to the UMMS corporation assets worth $66.5 million, including $51.5 million in real estate and equipment, such as the land and buildings that make up the University Hospital complex and all of its furnishings, from scalpels to CAT-scan machines. Since then, the corporation has received, at no cost, state subsidies of about $6.2 million a year to operate the three hospitals combined (no other private hospitals in the state get similar subsidies), title to the new Shock Trauma center on Redwood and Penn Streets that was built with $42.9 million of the state's money, and virtually unchallenged control (through Shock Trauma) of the state's new fleet of nine Med-Evac helicopters, acquired last year at a cost to Maryland taxpayers of $41 million.

The expectation that the hospitals would become self-sufficient also hasn't been realized. State Health Services Cost Review Commission records show that in every year since privatization, the hospitals have earned less than the amount of the state subsidy. If the subsidies are subtracted, the three hospitals combined have actually lost an average of $3.3 million each year since privatization.

Shock Trauma's losses have been the greatest, although finding out exactly how great is somewhat difficult. (Before the UMMS takeover, according to several long-time Shock Trauma employees, the center consistently broke even or showed a modest profit.) In response to a request for profit-and-loss statements, the UMMS corporation provided computer print-outs showing losses of nearly $1.5 million between July 1988 and June 1989—supposedly the first losses in Shock Trauma's history. Records the corporation filed with the state, however, show a $2.6 million loss for the identical period. Both records claim to be final, audited Shock Trauma figures. The state records further show that since July 1, 1984, the center has lost in excess of $4.4 million, not the $1.5 million the corporation claims. Many people who work at Shock Trauma say total losses at the center are expected to reach $9 million by the end of 1990.

Even so, the corporation maintains that the three hospitals, as a whole, have been operating in the black. In February 1990, UMMS president and chief executive Dr. Morton I. Rapoport and board chairman Roger C. Lipitz testified before the Maryland State Senate's Budget and Taxation Committee and the House of Delegates' Appropriations Committee that the corporation had shown a profit for six straight years and therefore should receive $65 million from the state over the next three years to build a new medical center complex on the University of Maryland at Baltimore (UMAB) campus. The corporation has refused repeated requests for explanations of these discrepancies.

Privatization placed Shock Trauma in a regulatory limbo, where it benefits from the budgetary secrecy of private management (the salaries of corporate administrators are not open to the public, for example) while it continues to enjoy the state subsidies and the widespread public belief that it is a state institution. Reports from insiders that Rapoport and the four top UMMS officials received pay increases totaling $147,000 shortly before 49 veteran nurses and middle managers were laid off or took salary cuts at University Hospital and Shock Trauma in 1989 can't be confirmed by a look at public documents: there aren't any.

Privatization also has created an even more significant problem. It has placed essentially the entire statewide emergency medical services (EMS) system under the control of the private doctors who work at Shock Trauma.

State of SHOCK

One of R Adams Cowley's chief accomplishments at Shock Trauma was to organize a system that could deliver victims to the best possible hospital in the shortest possible time. Formerly, ambulances had simply rushed trauma victims to the nearest medical center regardless of whether or not it had the resources to handle the injury. Doctors were expected to treat whatever rolled through the door, from burns to severed hands, from children to adults. Severely injured patients were sometimes transferred to specialized centers in Baltimore, but that almost always happened after they were admitted first to a community hospital and the doctors there had decided that the injuries were beyond their ability to address. Specialized hospitals, for the most part, stood like life rafts on the high seas—isolated and available only to those nearby.

Cowley believed that victims had the best chance of survival if they could reach a life raft within 60 minutes after the accident—a period Cowley dubbed the "Golden Hour." Using helicopters and radios, he linked the state's hospitals into a network that had never existed before. The system worked like an old-fashioned telephone switchboard. A central phone bank, staffed by doctors and state police, took emergency calls from all over Maryland and routed the patients (via helicopter or land ambulance) to the appropriate hospitals. People with minor injuries could still go by land ambulance to community hospitals. But victims of serious accidents could be rescued from virtually anywhere in the state and delivered into the hands of specialists within Cowley's "Golden Hour." Burn victims, for example, were routed to the burn center at Francis Scott Key Medical Center, where specially trained doctors and special burn equipment were available. People with damaged or severed hands were sent to the hand center at Union Memorial Hospital.

Because of its central location and because Cowley worked there, Shock Trauma quite naturally became the hub of the system. The switchboard, known as SYSCOM, was set up next door to Shock Trauma's operating rooms and heliport. It was supervised by the Maryland Institute for Emergency Medical Services Systems (MIEMSS), a state agency that ran both Shock Trauma and the so-called "field service" responsible for controlling the network of ambulances and hospitals.

The arrangement worked well before Shock Trauma was privatized. Cowley, as director of MIEMSS, rode both horses: he supervised the trauma network (with its switchboard and helicopters) and he supervised Shock Trauma. He reported to the taxpayers through the Board of Regents at UMAB. Cowley also enforced state guidelines that capped doctors' salaries and fees. While the doctors received salaries from the state, they also billed and collected fees from patients for their medical services through an organization called Shock Trauma Associates, Professional Association (STAPA). Cowley never operated on patients or billed for his personal services while he was MIEMSS director.

After privatization, the doctors were no longer bound by state salary guidelines. They were free to vote to increase their own payments from STAPA and to award themselves bonuses—increases and bonuses Cowley repeatedly opposed.

The doctors also assumed a greater role in dispatching the state helicopters. Formerly, the helicopters were governed by rules written by Cowley. A few years after privatization, a "trauma line" was established, and Shock Trauma doctors shared among themselves the duty of manning it. The doctor on duty essentially performed medical triage over the radio linking the hospital to the paramedics in the field. The doctor at Shock Trauma increasingly made decisions about which patients would receive helicopter transports and where they would go. A new set of rules to govern the triage was in the works under Cowley, but it has not appeared since his departure.

Today, eight Shock Trauma doctors who share the trauma-line duty exercise essentially complete control over the way the state helicopters are dispatched for medical missions. Their decisions have drawn increasing criticism from doctors at outlying hospitals, who report that it is increasingly difficult to obtain helicopter service to move patients from the community hospitals to the specialty centers. They say the helicopter system is geared toward trauma victims being rescued from the scene of an accident—the type of patient Shock Trauma is designed to serve.

Other sources, speaking from within Shock Trauma, have challenged the quality of care being delivered to patients at the center. UMMS president and chief executive Rapoport vigorously denies that the quality of care has gotten worse since the corporation took over Shock Trauma, despite the financial losses. "Patient outcomes have steadily improved at the Shock Trauma center," Rapoport states in a written response to an interview request. "At a time when trauma systems throughout the country are under enormous fiscal constraints and there is serious concern for quality of care in these systems, we are proud that the Maryland Shock Trauma System has maintained its quality."

As proof, he claims that the survival rate of patients admitted to Shock Trauma has surged from 80 percent in 1977 to 92 percent in 1989. The 92-percent survival rate that Rapoport cites is misleading, however, because it includes trauma patients who were re-admitted for follow-up care, such as plastic surgery, as well as non-trauma patients admitted for elective treatment. In other words, the figure gives UMMS credit for saving people whose lives were never in danger.

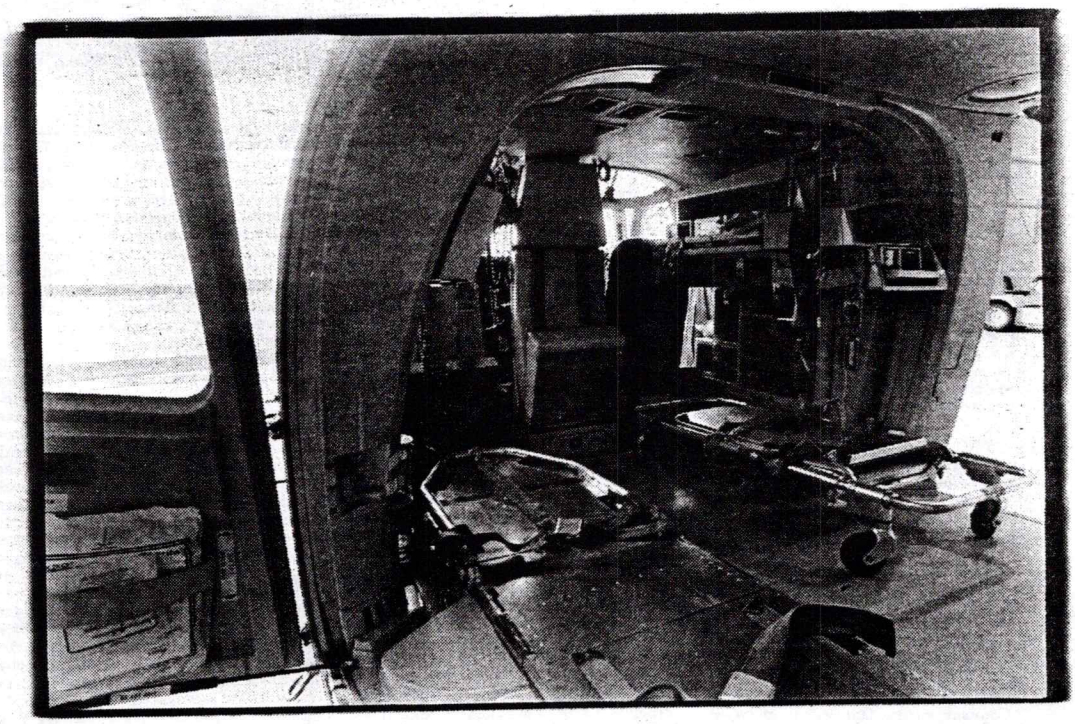
Rapoport also says patients are logging shorter stays—10.6 days on average last year, down from 13.5 days in 1983. This trend, he asserts, is an indication of better care, not worse. But again the figures are skewed, and for the same reason: people admitted for elective or follow-up treatment aren't likely to stay as long as severely injured trauma patients—and such admissions have increased more than 350 percent since privatization, according to internal hospital records.

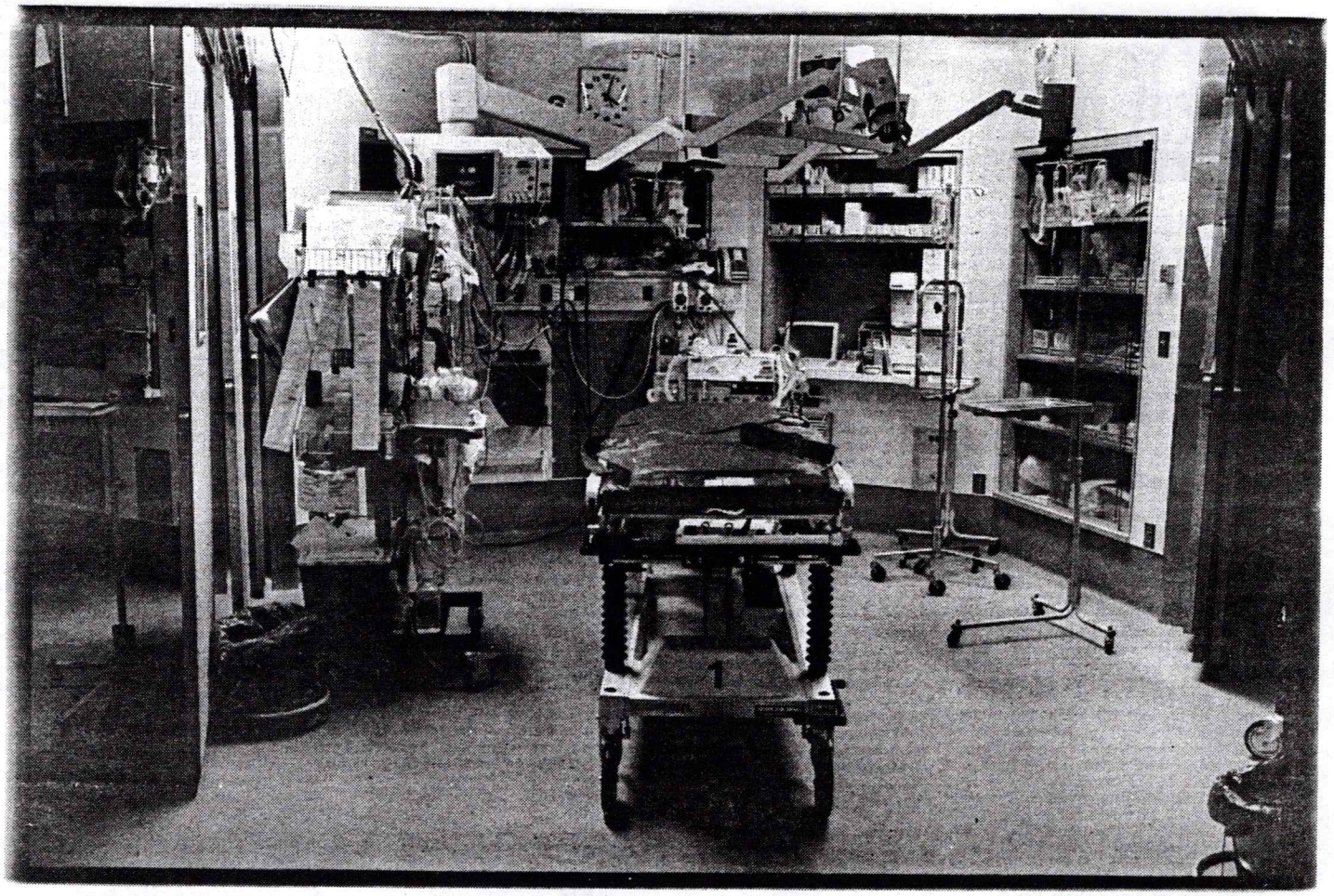
Meanwhile, doctors and nurses who have worked for dozens of years in Shock Trauma's wards report that the staff shortages and hostile work atmosphere that have developed since the corporation took over are affecting patients on a daily basis. Low morale and concern for the quality of care was documented as early as August 1985, when 37 nurses attempting to unionize Shock Trauma explained their reasons in a letter to *The Evening Sun*. With "the takeover of Shock Trauma by the UMMS cor. oration from the state," the nurses wrote, "the quality of care is being threatened. Nursing positions have been eliminated in each unit of Shock Trauma, thereby decreasing the amount of time the nurses can spend with the patients and their families." The union drive ultimately failed.

The existence of hostility and low morale is further indicated by the actions of the scores of nurses who have quit their jobs at Shock Trauma in the last few years—apparently because they would rather switch than fight with their new bosses. From July 1988 to June 1989, 34.7 percent of the more than 300 nurses at Shock Trauma quit their jobs, well above the statewide average of 19 percent recorded by the Maryland Hospital Association for all nurses over the same period. (A statewide comparison specifically for trauma nurses is not available.) Between July 1989 and June 1990, the pace of departures from Shock Trauma eased slightly to 32.3 percent overall, but it has quickened to 49.9 percent (up from 47.3 percent) in the multi-trauma critical care unit, which treats the sickest patients, and to 40 percent (up from 34.6 percent) in the neuro-trauma subacute unit, which handles brain-injured patients. The statewide rate, meanwhile, has slowed to about 18.5 percent. During this two-year period, the UMMS corporation cut 47 of 349 nursing positions from Shock Trauma's budget, a move that lowered the ratio of nurses to beds by 19 percent, from 3.2 to one in fiscal year 1988 to 2.6 to one in fiscal year 1990.

Rapoport of UMMS says that many nurses left because they didn't like transferring from Shock Trauma's old, cramped medical quarters at University Hospital to spacious and better-equipped wards at the new, $42-million R Adams Cowley Shock Trauma Center in February 1989. Connie Walleck, a former nursing administrator at Shock Trauma, explains that the old facility was smaller, creating the impression that there were a greater number of seriously injured patients. In the new building, where critically injured patients are not placed as close together, some nurses no longer felt that they were part of an "elite team." Leaving the old facility, Walleck says, "clearly was an emotional separation." Rapoport also says that many nurses were lured away by better salaries paid by rival institutions.

Three surveys conducted by the nurses in 1989, however, contradict these explanations. Of 52 nurses polled in exit interviews, none said salary was a reason for leaving Shock Trauma. Poor management—which they said created confusion, heightened hostility among nurses, and caused a decline in patient care—was the chief reason they gave for quitting. Although seven nurses stated that they left "for reasons directly related to the move into the new building," according to one survey's summary, all seven said they were more angry about the "lack of honesty by administration regarding the move" than by the actual changes that occurred. A majority of nurses also said they left because, as the demands of the job grew under UMMS management, they felt care slipping and saw few if any rewards. "The workload was up and the manpower was down," says Elizabeth H. Scanlan, who was





Shock Trauma's nursing director for 27 years before leaving a year ago. "It has to have an effect on patient care because the job gets harder and harder, and you don't do things you should do and you make mistakes."

One of the technological advances in the new Shock Trauma building is a computer that calculates the number of nurses needed every day and helps nurses determine which patients require one-on-one attention. Each room in the 138-bed center has its own computer terminal, where nurses are supposed to key in patients' conditions. The computer, in turn, spits out care instructions and staffing requirements (including nurse-patient ratios) that nurses say are routinely ignored. Half the time, the nurses add, the computer isn't even used.

UMMS officials deny that nurse-patient ratios have been compromised. However, Shock Trauma clinical director Dr. Phil Militello allows that, under special circumstances, "if a nurse felt a one-to-one combination was called for and they didn't have the staff, a two-to-one combination may have occurred." This means that patients who, in the view of the nurses responsible for setting nurse-patient ratios, needed a nurse dedicated solely to them instead received care from a nurse who also was responsible for another patient. It means that nurses had time to focus on only the most critical needs of their patients and that they cut corners where they could.

Consoling victims' families, though important, was among the first tasks to be given short shrift, along with a host of minor procedures that guard against infection and make patients more comfortable. "It's safe to say that on every shift, every day, every week, and every month there are things that are not getting done that should get done," says a current nurse who asks not to be identified. "Patients don't get dressing changes, they don't get [intravenous] line changes, they don't get baths, they don't get suction" as frequently as hospital procedures require, she adds. Says another current nurse, also speaking on condition of anonymity, "You've got 23 hours worth of work that you need to do in 12 hours. *That's* why we're quitting."

Part of the nurses' dissatisfaction seems to have stemmed from the ouster of R Adams Cowley, Shock Trauma's founder and guiding force. Raised on a ranch in Layton, Utah, the great-great grandson of a woman who crossed the Great Plains with Brigham Young in the Mormon migration of the late 1840s, Cowley grew up breaking wild horses and racing automobiles. His brash spirit got him kicked out of high school five times and out of college once. But it was also one of the things that enabled him to build Maryland's EMS system.

He went to medical school at the University of Maryland and specialized in thoracic (chest) medicine. After World War II, he developed a theory about how to treat trauma victims that revolutionized the field. The theory was simple but startling: treat accident victims for shock before diagnosis. "Our whole goal is to keep the patient alive," he said in a 1982 interview in *Sun Magazine*. "If you stop to diagnose, half your patients are dead." Treatment depended on providing a massive response for a massive injury in the shortest possible time. "You don't need great science," he said. "Or a great hospital, or a great doctor. All you have to do is get the community organized into a system of care."

Cowley also had revolutionary views about nurses. In a world that treated nurses as if they were doctors' handmaids, Cowley treated his with deep respect and appreciation. He provided educational opportunities and gave them decision-making power. "Nurses are overworked, over-exploited, and under-utilized," he said in the same interview. "In my thoracic [chest] surgery, a nurse was treated like a doctor, and they didn't have to do anything a doctor didn't. We'd have seven- and eight-hour operations, and they'd miss lunch, so I'd take them all out to dinner at Sabatino's afterwards, trying to pay them what the university didn't."

Cowley's methods, however, rubbed many people the wrong way. He poured relentless energy and dedication into his job, worked continuously, and thought of little else. And he demanded his staff do the same. He bruised many egos and stepped on countless toes with his brusque, no-nonsense manner. He spoke up bluntly if he disagreed. He opposed bonuses for doctors who hadn't done more than was required, which touched off tempers. He also stood up to the corporate managers after the UMMS takeover in 1984. "If he was sitting at a board meeting and they were telling him that he had to cut back on supplies, he would say 'Go to hell!' " says a former member of his staff who requested anonymity. "Cowley opposed the corporation. He thought the management didn't understand the philosophy or needs of Shock Trauma. He believed services should be provided regardless of cost. He believed that you can't put a price tag on a human life."

Although Shock Trauma's doctors still sought Cowley's opinion on medical matters, they found themselves caught between two conflicting bosses. "The doctors got [stuck] in the crossfire," says Shock Trauma clinical director Dr. Phil Militello. "If we were losing money, the corporation would say we had to cut positions and freeze salaries. Cowley would say 'Don't cut, don't freeze.' " Secretly, some of the doctors began to plot Cowley's removal. In the opinion of many, from orderlies to editorial writers at *The Sun*, Cowley had simply become too powerful and seemed unwilling to share power with any but a few close associates whom he trusted. In May 1987, Cowley began to think about going into research and started scouting for a person who could replace him as head of Shock Trauma. It was a difficult position to fill, since the new head would need to be both a highly respected, well-credentialed trauma surgeon and a strong administrator.

Meanwhile, problems persisted in other parts of the Shock Trauma operation. The field service—the system of ambulances and helicopters that delivers patients to hospitals—was not running as Cowley wished. The head of the field service, Dr. Ameen I. Ramzy, had been a Cowley protege and a top student at the medical school. But Cowley objected to the fact that Ramzy continued to operate on patients while serving as director of the statewide EMS system. Though Ramzy maintains he never acted out of self-interest, his position in fact gave him direct control over the dispatch of helicopters that brought in patients for him to operate on.

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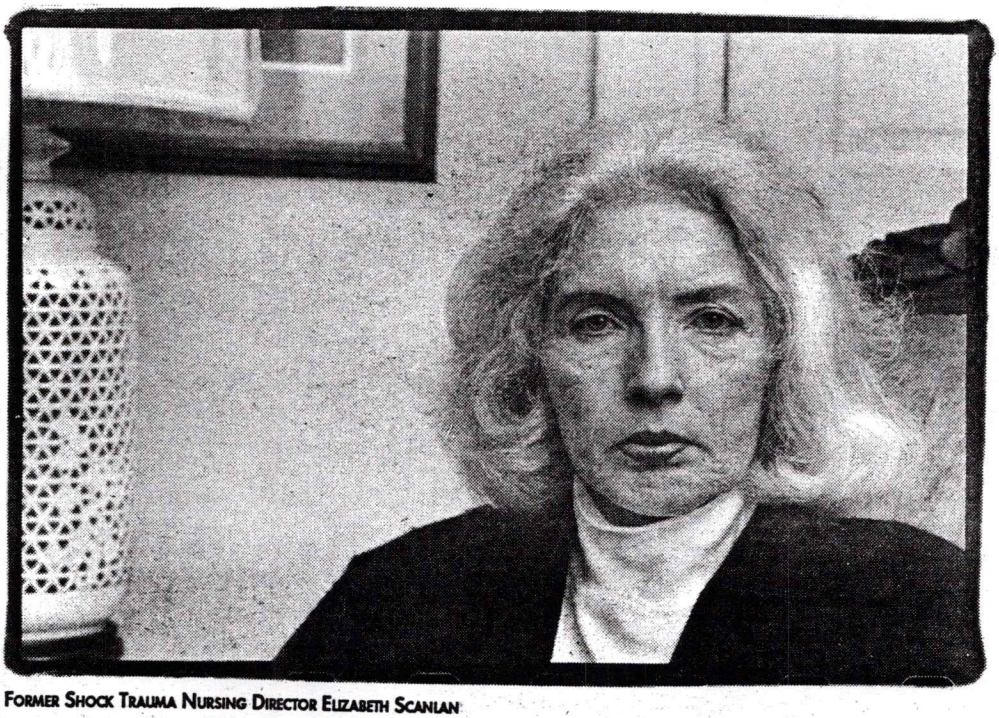

FORMER SHOCK TRAUMA NURSING DIRECTOR ELIZABETH SCANLAN

To eliminate this apparent conflict of interest, in May 1988, Cowley took away Ramzy's title as statewide EMS director and took back the control of the statewide EMS budget. Ramzy resigned in protest, and rallied EMS and fire battalion chiefs from around the state on his behalf. Under pressure, Cowley reinstated Ramzy in July 1988. Cowley and Ramzy "didn't see eye to eye on anything," former nursing director Elizabeth Scanlan recalls. "It got to the point where the only way they could communicate was by letter [even though they worked just a few offices apart]."

The animosity between the doctors and Cowley had deepened, meanwhile, largely because of Cowley's opposition to the doctors' salary raises and bonuses. He repeatedly vetoed bonus payments from STAPA, arguing that the money should go instead to bolster the hospital and fund research. According to people who attended STAPA meetings, Cowley repeatedly vetoed bonuses of up to $15,000 that doctors expected to receive two or three times a year.

In May 1988, the doctors wrote a letter to Cowley protesting Ramzy's resignation. It was the first in a series of letters in which the doctors detailed their complaints against Cowley. He was accused of concentrating too much power among his inner circle of administrative staffers and of playing favorites. The doctors also complained that Cowley had blocked their bonuses. The May letter was signed by the 16 physicians who are partners in STAPA. In the summer of 1988, Cowley brought in consultants and established an executive management board, which for four months tried without success to hash out the doctors' grievances.

In November 1988, the doctors sent Cowley a second letter protesting his firing of the executive director of MIEMSS, John Ashworth, who had set up several subsidiaries of STAPA that were used to invest STAPA funds. Cowley said the subsidiaries created further conflicts of interest for the hospital. Ashworth was subsequently hired as a vice president of the UMMS corporation.

By the spring of 1989, Shock Trauma had lost a sizable amount of money, and that fact was added to the case being built to force Cowley out. On May 2, 1989, the doctors sent a final letter that, unlike the others, didn't detail complaints. It simply expressed a vote of no confidence in Cowley. Militello, one of the letter's 16 signers, said that the doctors expressed their lack of confidence because they felt Cowley had adopted a "bunker mentality" and because his health was failing. (Cowley has suffered bouts of heart illness in recent years.) This last letter wasn't sent to Cowley, as the others were, but instead went directly to UMMS board chairman Roger C. Lipitz.

When Cowley learned about it, he called his inner circle into his office for advice. They told him to confront the doctors and to ask what they wanted. A meeting with the doctors, held a few days later, went like this, according to sources who attended: Cowley walked into a meeting room in the old Shock Trauma center. The doctors who had signed the letter were gathered around a table, along with State Senator Francis X. Kelly (D-10), a UMMS board member since 1984.

"Does anybody have anything they want to say?" Cowley asked.

There was silence.

"Does anybody have any questions?"

Again, no one spoke.

"Have you elected a spokesman?" he demanded.

Dr. C. Michael Dunham, a Shock Trauma surgeon, spoke up. He said the doctors felt that for a period of time Cowley had been "supportive and very constructive" with the Shock Trauma system, the sources say, but that they felt that wasn't the case anymore. He had now become "destructive" to the system, and it was "time for him to move on."

On May 13, 1989—a few days after the meeting—at a black-tie gala fund raiser for Shock Trauma, Governor William Donald Schaefer stopped the band to announce that Cowley would retire from his post as statewide EMS director in order to head the university-based Charles McC. Mathias, Jr., National Study Center for Trauma and Emergency Medical Systems. "He will move up and he will move over to the national study center he has thought about and dreamed about for so many years," the governor said.

Cowley declined to comment for the newspapers that night and has remained mum on the subject ever since. Many of the sources for this article maintain that as a condition of being named head of the Mathias National Study Center, Cowley was required to sign a contract that forbade him from speaking publicly about the circumstances of his leaving Shock Trauma. Despite repeated requests, no copy of such a contract has been made available. (Cowley declined to be interviewed for this article.) He was hospitalized in September 1989 after suffering a third bout of congestive heart failure in three years. He now works one or two days a week at most at the study center.

Cowley's removal as head of Shock Trauma brought on more resignations, which worsened financial deficits and further depressed morale. In May and June 1989, when the number of trauma accidents in Maryland began its seasonal rise, 30 nurses quit their jobs at Shock Trauma in a single week. Without the nursing staff to handle the patient load, Shock Trauma essentially closed its doors, a condition known as "flyby." Patients who would normally have been taken to Shock Trauma were instead flown to other hospitals, such as Sinai, Johns Hopkins, Francis Scott Key, and University Hospital. In April 1989, there was one instance of flyby at Shock Trauma. Between May and September 1989, there were 166 instances.

These lost admissions took a toll on the hospital's profits and on its morale. "Dr. Cowley's removal was very abrupt and very confusing and demoralizing for most of the staff because Dr. Cowley had developed the system," says Elizabeth Scanlan. "Some of the nurses didn't like the way [Cowley's removal] was accomplished. They were and are concerned about their own destiny because Dr. Cowley was always a supporter of nursing."

Cowley's replacement as MIEMSS director was Dr. James P.G. "Seamus" Flynn, former director of the Montebello Rehabilitation Hospital. Montebello is managed by the UMMS corporation through a contract with the state Department of Health and Mental Hygiene. Flynn, who received his medical training in internal medicine, has no training as a surgeon and no experience with treating accident victims. He is widely described as a "team player."

As a condition of his departure, Cowley was allowed to appoint an "acting director" of MIEMSS. He chose Flynn, and a search committee was set up to find a suitable permanent MIEMSS director. According to Militello and other sources, the committee never even established a job description or a set of criteria for selecting the new director. In March 1990, Flynn's appointment was made permanent. Flynn's position, however, is largely as a figurehead. The actual day-to-day operation of the field service and the Shock Trauma hospital is handled by Ramzy and Militello, respectively.

With Cowley gone, some have asked what was gained by the ouster. "We lost the man who gave his entire life to the system," says Bette Beggs, Cowley's former administrative assistant. "He was a watchdog. Sometimes he might have barked too loud, and people didn't like it. But who's barking now?"

Not surprisingly, the doctors have begun to bark, now that UMMS and the medical school are moving to take greater control of the Shock Trauma center. The loss of autonomy, the doctors say, could worsen patient care and may spark mass resignations. "If the organizational relationship [with the medical school] no longer prioritizes patient care," says Ramzy, "then some very talented and experienced people will consider other options and other places to work." Adds Dr. Howard Belzberg, a Shock Trauma specialist in internal medicine, "The plan fails to grant MIEMSS the necessary autonomy and neutrality it needs to operate."

Other members of the medical community not involved in the conflict say that Shock Trauma has moved beyond the stage where the quality of patient care requires independence. They contend that the doctors are protecting their autonomy so they can continue to allocate the fees that STAPA collects in the way they always have. A med school takeover would change the way STAPA money is distributed, forcing STAPA to conform to more rigorous guidelines used by doctors at the medical school. It would also require Shock Trauma doctors to share information about their personal incomes with the medical school faculty. But some critics say the plan does not go far enough to resolve larger statewide EMS issues—it does not provide a mechanism for auditing all Shock Trauma records, nor does it eliminate conflicts of interest related to the EMS system. The UMAB Board of Regents is expected to reach a decision about the plan when they meet at the end of this month.