

Maryland

E•M•S

NEWSLETTER

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For All Emergency Medical Care Providers

Sept./Oct. 1989

Maryland EMS – Where Are We?

Sixteen years after the Maryland EMS system was established by the Governor's Executive Order, intense and healthy discussions continue. The focus of discussion has, of course, changed from whether there should be an EMS system at all, to where the system is now and where it should be in 16 more years. Every system has an obligation to examine itself and to look at both its accomplishments and its challenges. It is hoped that this discussion will be the first of a series of articles to encourage further information exchange within the Maryland EMS community, to encourage an active and open dialogue on issues of interest in Maryland.

Maryland has a fully integrated and mature statewide EMS system that has evolved and continues to evolve to meet the needs of the citizens of the state. While "the whole is greater than the sum of the parts," each part or component of the Maryland system is important, and the strength of the system is based on the completed integration of these components. Maryland's leadership has developed from its ability to look ahead and evaluate that which is new through a critical appraisal process. This process may begin at the local level and it includes considerations not only of anatomy and physiology, but also all the components of the system, such as demographics, geography, and medical interventions in the context of response to patients' needs. Key factors in Maryland EMS are not only that the components are in place but also that they are functionally inter-related and coordinated.

EMS response to an incident begins with recognition and access to the system. Maryland's 911 emergency telephone access system (with oversight by the State's Emergency Numbers Board) provides 100 percent coverage statewide. Citizens have immediate access in each of the 24 jurisdictions to central alarms for all emergency services – that is, fire, police, and EMS. Nationally two states have 100 percent 911 coverage, according to a 1988 survey; a more recent survey suggests that this number has increased to four states. (However, even some communities with 100 percent 911 coverage for EMS do not necessarily have complete 911 coverage for fire and police services.)

One of the implications of the 911 system is that citizen access to emergency services shortens response time, thereby influencing the need for the appropriateness of certain field interventions. In other words, in

communities without a 911 system, specific interventions which may involve greater risk may be needed more frequently because the response time is longer than it might otherwise be.

A dominant issue in EMS in recent years has been that of trauma care systems, recognizing that a trauma system is in many ways a sub-set of an entire EMS system. An independent review published in the *Journal of the American Medical Association (JAMA)*, June 24, 1988 – Vol. 259, No. 24) concluded that Maryland was one of the only two states in the country (the other is Virginia) which has a trauma system containing all the necessary components. (A copy of this article is available from the EMS regional offices of MIEMSS.)

In addition to 11 trauma centers, Maryland is fortunate to have established specialty referral centers

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Maryland's EMS system has evolved to meet the need of the citizens of the state.

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for pediatric trauma, burn injuries, eye trauma, and severe hand injuries; in addition to these specialty referral centers for trauma, there are specialty referral centers for neonatal and perinatal emergencies. Prompt transportation by highly trained EMS providers is provided not only by over 450 ambulance companies statewide, but also by the Maryland State Police Aviation Division Med-Evac helicopters.

One of the questions which arises in the discussion of prehospital care of trauma victims is that of chest decompression in the field. A study done in the early 1980s by Dr. Alasdair Conn, then medical director of the MIEMSS Field Program, based on statewide autopsy reports, stated that unresolved tension pneumothorax in the field was never the sole cause of death in the trauma patient. However, providers in Maryland are sometimes confused and frustrated when they hear about EMT-paramedics in other parts of the country performing chest decompression. We do not know whether chest decompression performed in other parts of the country by EMT-paramedics is based on local system preference or if it is based on an identified patient need in that particular area. Certainly there are parts of the country with significantly longer transport times, which may indeed require more intervention to benefit the patient. However, we continue to track activity in Maryland to see when, whether, and how such intervention would be appropriate.

Another item of interest and discussion is that of cricothyroidotomy (placing an airway into the neck through the skin and cricothyroid membrane either with a large needle or with an incision) in the field. A recently completed national survey was conducted by the Maine EMS Director, Kevin McGinnis, through the National EMS Clearinghouse of the Council of State Governments. Of 49 states responding, 15 used needle cricothyroidotomy, 4 used surgical cricothyroidotomy, 13 used both needle and surgical cricothyroidotomy, and 17 did not utilize cricothyroidotomy in prehospital care. Use of the intervention did not mean total use throughout the state, but simply whether it was utilized at all or not. Of the 49 states responding, there were no data available from the state EMS

offices regarding survival, benefits, or complications.

Recent developments in cardiac care have focused renewed attention on this area of EMS prehospital care. Some parts of the country are testing the use of thrombolytic agents (medications designed to dissolve blood clots in the coronary arteries which may be causing a heart attack). Several trials involving these thrombolytic agents in prehospital care are currently underway around the country. Some of these are based on the realization that there is a delay in patient recognition and access to the system, specifically because of denial of chest pain and chest discomfort until the symptoms are very pronounced. This problem of delay because of denial has, in the past, been compounded by a further delay in hospital response in promptly recognizing patients who need to have thrombolytic therapy initiated. However, with the more widespread use of thrombolytic therapy, such care is now widely utilized in emergency departments throughout the country, although in some areas this is only under the specific direction of cardiologists.

Regarding prehospital cardiac care in Maryland, calendar 1988 Maryland Ambulance Runsheet data suggest that suspected cardiac patients in the field have a remarkably consistent total mean time in the range of 35 to 45 minutes (average 39.1 minutes) from the initial call to arrival at the hospital. While cardiologists have emphasized the need for rapid transportation of cardiac patients, they have also supported our Maryland ALS protocols as the essential minimum requirement for patient care in the field. While we will continue to watch with interest the results of thrombolytic intervention in the field, we remain concerned about the possible risks to patients because of the difficulties in establishing a diagnosis of myocardial-infarction in the field, in contrast to the prompt access to emergency departments with this therapy available throughout the state.

During the past years, there has been more than one peak and valley of interest in EMT-defibrillation across the country. Recently, there has been another national resurgence of interest. One pilot study in Maryland indicates that the implementation of EMT-D has to be very carefully planned and very carefully monitored to determine if it will be of any benefit in a given

community. Therefore, any future implementation of EMT-D in Maryland will be based upon very careful analysis of existing community conditions (that is, volume of calls, BLS and ALS response times, resources utilized, and patient outcomes). A preliminary analysis of initial data from one area suggests that although there was an excellent response time for BLS, there was also a superb mean time for medic unit response of 5.0 minutes to cardiac patients, suggesting that the addition of EMT-D would be of very little if any further benefit. These preliminary data are being further analyzed.

Advanced Life Support protocols (the Maryland Medical Protocols for CRTs and EMT-Ps) are statewide in Maryland rather than locally based. This provides for a "common language" among all prehospital ALS providers and consulting/receiving physicians, so as to prevent or minimize a mosaic of activity across the state. One of the questions that sometimes arises relates to the appropriateness of pharmacologic intervention in the field. Under existing ALS protocols, there are 11 "statewide minimum" ALS medications required of all ALS programs, and a list of 7 "maximums" which may be selected on a regional basis. However, to move closer to a unified ALS protocol, the "optional drugs" were tracked in the course of the current protocols. On the basis of this, we were able to measure frequency of utilization and to judge the patient benefit of specific drug interventions. This information was then utilized to make additional decisions regarding which ALS medication should be in the protocols. We know of no other EMS system that has used a tracking system to attempt to objectively evaluate the benefits to patients of drug intervention in the field. The important point to stress is that as EMS providers our obligation is to serve patients' needs rather than to serve our own wishes. As a result of the evaluation, certain medications were dropped from the ALS drug box, while others were added to statewide minimums. There will be 13 statewide minimum ALS medications, and 2 additional ALS maximum statewide for further evaluation. With a remarkable consistency of response times around the state, from metropolitan to rural jurisdictions, and the obvious fact that anatomy and physiology are the same

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in all parts of the world, it seemed logical that if a medication were of benefit to patients in one part of the state, then that benefit should be extended to all patients.

The use of external jugular intravenous lines in the field was also considered during the most recent ALS protocol review process. This recommendation was accepted, and external jugular intravenous lines will become part of the therapeutic regimen available to Maryland certified EMT-Ps, when the revised ALS protocols become effective January 1, 1990.

In concert with the Maryland medical protocols for cardiac technicians and emergency medical technician-paramedics, and in response to recommendations from many in the state, we will soon initiate the process to develop the Maryland Medical Protocols for EMT-As.

While it is appealing to look at new modalities and new advances, it is also essential and possibly more important to look at the baseline of care which is provided to all in the state. Utilizing the MAIS (Maryland Ambulance Information System), certain useful data can be extracted. (In November, we will restart the process to initiate revisions to the MAIS runsheet, in the hope of making it both easier to fill out and of greater utility to all who complete it.) Of several hundred thousand records for a one-year time frame (98.2 percent indicating the certification level of the prehospital EMS provider), 99.48 percent of the calls had an EMT-A or above (that is, EMT-A, CRT, or EMT-P). We are tremendously proud of the thousands of prehospital EMS providers, both volunteer and career, who make such a response possible.

As EMS Director and Medical Director for Maryland, I welcome active dialogue on issues involving patient care. Questions from Maryland EMS providers receive thorough consideration. We all want to do the best thing for the patients we serve. While it may be appealing to immediately introduce a new therapy, it is important that all of us view ourselves as patient advocates in every sense of the word. What may initially appear to be appealing, may turn out to have significant risks as well as benefits. We have to constantly weigh those risks and benefits and evaluate the best

intervention for patients in need of emergency care, keeping in mind, as the prehospital ALS protocols state, "the goal of prehospital emergency

medical care is to deliver a viable patient to definitive care."

♦ *Ameen I. Ramzy, MD*
State EMS Director

MIEMSS Nursing Director Retires

In the late 1960s, Elizabeth H. Scanlan, RN, MS, was caring for patients who had undergone open heart surgery at University of Maryland Hospital. Seeking even greater challenges, she joined R Adams Cowley, MD, in the innovative treatment of patients in shock. Together, they took the first steps toward what would become the world's only free-standing medical facility devoted to the stabilization and comprehensive treatment of the victims of traumatic injury.

After 32 years of nursing, Ms. Scanlan is retiring from MIEMSS as director of nursing, effective October 31. Among her many career accomplishments, Ms. Scanlan counts the establishment of the first specialty nursing program, development of the concept of collaborative practice, and initiation of primary nursing care.

With increased understanding of the body's response to injury, Dr. Cowley and Ms. Scanlan, working in the two-bed trauma unit at the University of Maryland in the late 1960s, realized that nurses with a general education could not provide the comprehensive care needed by their critically ill patients. They started a specialty nursing program at Mt. Wilson Hospital that gave nurses the expertise they would need for this unique patient population.

"Nurses needed to understand what was going on within the patient, both physiologically and psychologically," Ms. Scanlan stated. "These skills produce better patient care and better systems of care."

She and Dr. Cowley also advocated the concept of collaborative practice, in which physicians and nurses work together as partners. Instead of maintaining the commonly accepted idea of nurses as "handmaidens," Ms. Scanlan says she "sought to confer on them the respect they deserve as professionals. In collaborative practice, physicians and nurses bring their expertise together not only to treat patients but also to solve administrative problems and to



Elizabeth Scanlan

develop plans for action and interaction in a variety of tasks."

What motivates a person to work so hard for so many years? Ms. Scanlan cites several factors that energized her career: "Two equally important forces were my desire to elevate the standards of patient care and to elevate the practice of nursing. I sought to establish the nurse as the most important force in the health care environment. Along with those goals, I was having a lot of fun! I have always enjoyed my work."

Reflecting on the changes that have come about during her 32-year-career, Ms. Scanlan notes that "health care professionals now look at trauma as an important entity. Maryland's Shock Trauma Center is viewed as a model to be emulated nationally, if not internationally. Our nurses are seen as professional, dedicated individuals. People in nursing and medicine come to this center to see the state of the art in critical care nursing.

In a letter announcing Ms. Scanlan's retirement, James P.G. Flynn, MD, acting director of MIEMSS, noted, "Her achievements will be difficult to emulate. Nurses, health care professionals, and the citizens of Maryland (especially trauma patients) have benefitted from her vision, work, dedication, and leadership."

Ms. Scanlan's immediate plans for retirement include a 3-month trip to Switzerland with her husband, Benjamin Trump, MD.

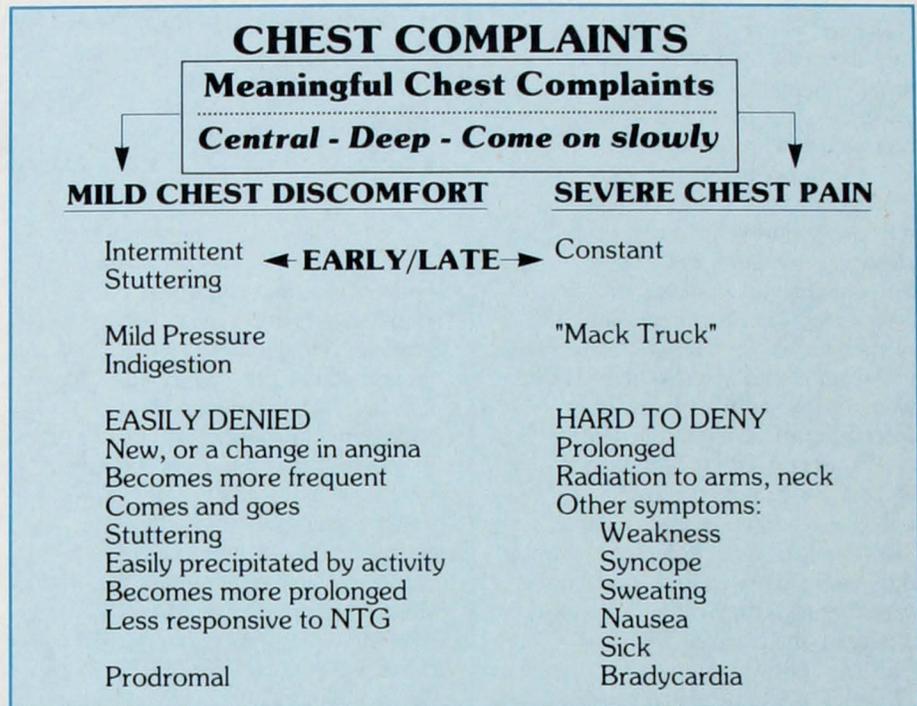
♦ *Linda Kesselring*

Early Cardiac Care Crucial to Prevent Permanent Damage

Recent advances in cardiac care have enabled clinicians to save more heart tissue in victims of "heart attacks" and thus to save more lives. All too often in the past, patients suffered extensive cardiac damage because they ignored the symptoms and signs of a coronary disorder. With the advent of thrombolytic therapy, *early cardiac care* has become the focal point for further advances in the treatment of this disease. Hospitals and community programs are helping to educate the public about the early warning signs of cardiac distress (see illustration "Chest Complaints").

Prehospital care providers are obviously involved in these changes: as more people become aware of the indicators of a cardiac emergency, ambulance runs will likely increase in number and become more difficult. It is estimated that 50 percent of patients seeking medical care for chest pain now arrive at emergency care centers by private car and the other 50 percent arrive by ambulance. If educational programs increase the awareness of chest pain as a risk factor for acute cardiac events, we can expect more work for prehospital care providers.

After the onset of chest pain in a person with coronary artery disease, three outcomes are possible: angina, acute myocardial infarction, or sudden death. The accompanying illustration presents the relative occurrences of each outcome in the United States. It also lists the goals for reductions in those percentages, which can be achieved by emphasis on early cardiac care and the respect for the early signs of a cardiac abnormality.



Potential patients may not have the typical syndromes or cardiac arrest or severe pain; they may have minimal symptoms, deny their problem, and resist going to a hospital (see chart). Creative ways of dealing with such patients must be worked out as the concepts of early cardiac care develop.

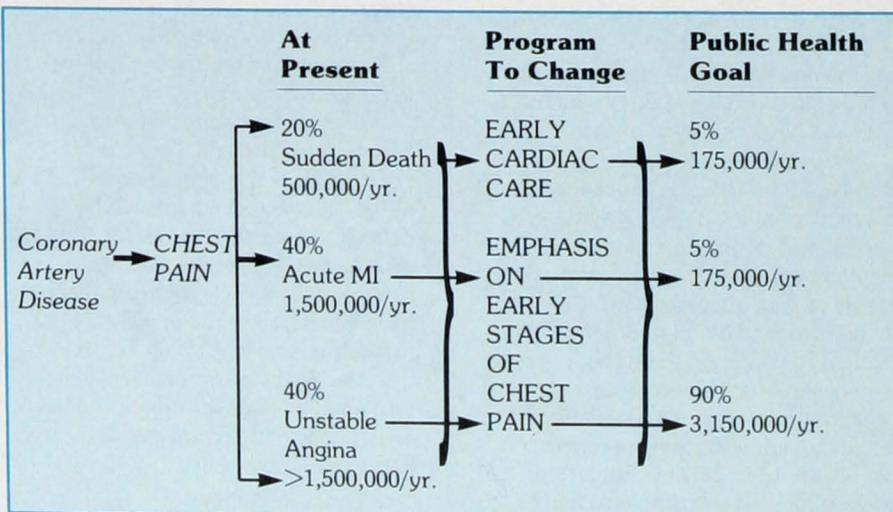
Patients who have chest pain and are reasonably stable should be taken to an emergency department expeditiously for possible thrombolytic therapy. The emergency department staff should be alerted that a patient with a possible cardiac emergency is on the way. *Time* is the real enemy once the patient starts having prolonged, unrelenting pain located centrally within

the chest.

A significant number of heart attack victims have beginning symptoms and signs for hours, days, or weeks prior to total occlusion of a coronary vessel. We are just beginning to realize the potential yield in establishing community programs to reach such individuals. The true focus for early cardiac care eventually will be centered on them: cardiac protection at that stage can salvage all the muscle in jeopardy and allow corrective steps once the problem has been defined by cardiac catheterization.

Thrombolytic therapy involves the use of drugs such as streptokinase or t-PA (tissue plasminogen activator) within the first 6 hours after a coronary vessel becomes totally occluded. Like trauma care, cardiac medicine has a "Golden Hour": maximum benefits can be reaped from medical intervention within the first hour after onset of the emergency. After that, the vessel can be opened with thrombolytic agents, but significant damage already has been done. Accordingly, it is incumbent on prehospital personnel to initiate treatment and transport the patient as efficiently as possible to ensure the salvage of the myocardial muscle.

These developments predict a very exciting future for cardiac care. The nation's leading health problem is being attacked by reducing primary risk



LEAST DENIAL

Late Stage — Complete
Heart Blockage

PROLONGED PAIN

Symptoms — Real pain
severe chest pressure,
heaviness, shortness
of breath — **FORCE**
victim to seek help.

BUT . . . permanent
damage is being done —
victim acted too late
to get greatest benefit
from medical care.

GREATEST DENIAL

Early Stage — Partial Heart
Blockage

STUTTERING SYMPTOMS

Warning Signs — Not "pain,"
but a nagging ache
or discomfort,
"indigestion" —
are **MILD** and so
victim denies the
problem and refuses
to get medical help.

BUT . . . care received
at this point does the
most good: it can
prevent heart attack
and even death.

Cardiac Care

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factors for the development of atherosclerosis and by taking quick action when the acute problem surfaces (chest pain). It is conceivable that the heart disease known as *heart attack* may be brought under control in the foreseeable future. Prehospital care providers will be a major part of that undertaking by understanding the changes that are occurring in cardiac care and being innovative with new approaches to patient care.

- ◆ *Raymond D. Bahr, MD*
Medical Director
Paul Dudley White Coronary
Care System
Saint Agnes Hospital

Licenses/Permits Needed for Commercial Ambos to Transport Patients into Baltimore City

A few out-of-town, commercial ambulance companies are objecting to the licenses/permits required if they transport patients into Baltimore City to nursing homes, doctors' appointments, or to another medical facility. These licenses/permits set standards for drivers and attendants, insurance, and vehicle safety.

Licenses/permits are not required for volunteer companies that are part of the 911 call system (or normally dispatched by a central alarm) and respond to and transport patients off-scene. Such companies have the implied approval of a county or municipality and are already following the protocols established by MIEMSS for the statewide EMS system.

More distant companies that come to Baltimore City only periodically feel the license/permit requirement is an imposition and the EMS system will be hurt if they no longer make the trip. It is true that in the rural areas, the time that it would take for an ambulance to make a run to and from Baltimore City (possibly several hours) might be an excessive strain on a volunteer company, so these commercial companies are filling a need.

Licenses are issued in June and July. As of July 1, a company license costs \$125 per year; a vehicle license is \$60. Companies that are licensed elsewhere may be able to obtain a waiver. A 2-year permit for the driver and/or attendant is \$25 per person.

An interim inspection is made about 6 months from the time of the

license issue. Unannounced cursory inspections take place at facilities in Baltimore City while the vehicle is in service; some of the major items checked are the operation of emergency warning devices, the condition of the tires, the adequacy of the oxygen supply, and the certification of the crew.

Whether a company is licensed or not, ambulances are not stopped or interfered with in any way while in the process of delivering a patient. However, notations are made as to whether the ambulance is licensed or not. An unlicensed company is informed that a license is required. If the company ignores the licensing requirement after the third notification, the case is turned over to the state's attorney's office for legal action, including, on rare occasions, impoundment and arrest. One extreme case, which followed a year-long investigation, involved a company with more than 30 charges against it, including having no vehicular insurance; some of its attendants were not even trained in first aid.

For a permit to be issued to a driver, a driving record in good standing is necessary. If a driver has 3 to 5 points against his/her record, a letter on the company letterhead is required ensuring that he/she is covered by insurance. A driver with 8 points or more will be denied a permit. The driver is required to have CPR training and either advanced first aid or first responder training.

An attendant is required to have a minimum of EMT-A state certification. Other training, such as in the military, is acceptable if it is equivalent. Waivers can be issued for appropriate experience.

It is also possible to obtain a combined driver/attendant permit. This requires EMT-A certification plus the driver's requirements mentioned previously.

Both driver and attendant are required to take a cursory physical, with vision and hearing testing. They are also asked if they have ever been convicted of a crime.

At present, there are 27 commercial ambulance companies licensed from Maryland, Pennsylvania, and Washington, DC. Of the 27 companies licensed, three are located inside Baltimore City. In FY 1988, there were more than 90,000 transports to, from, or within the city. Of that total, 46,000 were within Baltimore City, and the companies located within the city transported only 22,000 of them. The majority of runs were performed by companies located outside the city.

For further information regarding whether a company is subject to these licensing regulations, contact Irene Lumpkins, Baltimore City Health Department licensing officer, at 301-396-9408.

MIEMSS Nurse Gets Award from ENA

Patricia Epifanio, RN, MS, emergency nurse coordinator for MIEMSS EMS Nursing and Specialty Care Department, received the Judith C. Kelleher Award from the Emergency Nurses Association, September 7, at the association's annual meeting in Washington, DC. Ms. Epifanio was cited for her outstanding knowledge and expertise; for her contributions affecting the nursing profession within her community, region, and nation; for influencing emergency nursing as a speaker and writer; and for serving as a role model for emergency nurses.

New Region III Med'l Director Named

With the recommendation of the Region III EMS Advisory Council, Ameen I. Ramzy, state EMS director, appointed a new Region III medical director as of July. Alex P. Cadoux, MD, who has been the emergency department (ED) director at the Union Memorial Hospital in Baltimore for the past 5-1/2 years, has a diverse background in emergency medicine that includes doing a residency rotation at the Shock Trauma Center.

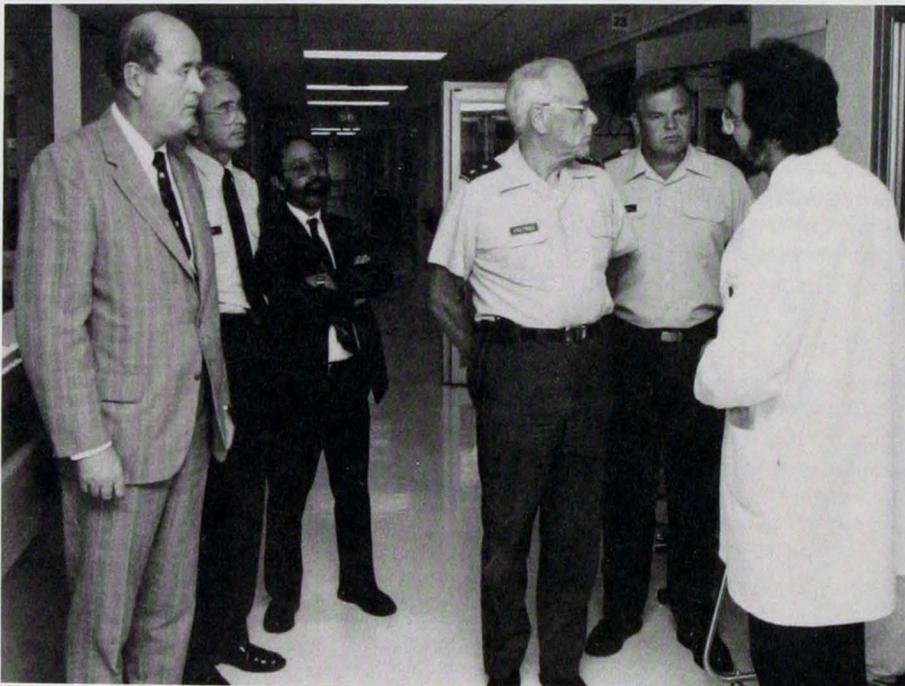
Dr. Cadoux helped to provide prehospital medical direction at consultation hospitals. He is a member of the Medical Advisory Committee for Ambulance Services of the Baltimore City Fire Department; the Med-Chi

EMS Committee; and the Maryland chapter of the American College of Emergency Physicians' EMS Committee, of which he was chairman for 2 years.

In cooperation with the Region III EMS Advisory Council, Dr. Cadoux is currently assessing the needs of the region and formulating objectives for FY 1990 as well as a 3-year plan. "We expect our emphasis to be on the implementation of quality assurance systems for both hospital and prehospital providers and we also hope there will be more physician involvement in evaluating runsheets and reviewing cases," Dr. Cadoux says.

Touring MIEMSS

Maj. Gen. James F. Fretterd, the adjutant general, chairman of the Governor's Emergency Management Advisory Council and State Emergency Response Commission, recently visited MIEMSS. Shown touring the new Shock Trauma building are (l-r) Dr. James P.G. Flynn (acting director, MIEMSS); Brig. Gen. Baker; Pete Cobb; Maj. Gen. Fretterd; Col. Barnes; and Dr. Ameen I. Ramzy (state EMS director and deputy director, MIEMSS). (Below, left) U.S. Senator Barbara Mikulski visited the University of Maryland Medical System, including the MIEMSS Shock Trauma Center. Here she is shown with Dr. James P.G. Flynn (acting director, MIEMSS) and Dr. Morton I. Rapoport (president and chief executive officer, UMMS). (Below, right) Members of the Maryland Senate Committee for Economic and Environmental Affairs recently toured the new Shock Trauma building. Shown (l-r) are Vice Chairman Sen. Arthur Dorman, Chairman Sen. Clarence Blount, and Dr. James P.G. Flynn (acting director, MIEMSS).



Drug-Related Fight Scenario for Frederick Drill



Police doing initial triage as the first units arrive.



EMS, police, and fire personnel work side by side in stabilizing patients (secondary treatment area).

On July 29, on the north parking lot of the Gov. Thomas Johnson High School in Frederick, a drug deal ended in a gang fight that killed four people and injured 14. When the police first arrived at the scene, they found a car ablaze with a man inside. The intensity of the fire made rescue impossible. Fortunately these events were only part of a drill to exercise various components of the Frederick police, fire, and EMS communities. Several dozen police officers, as well as EMS units from Walkersville, Middletown, Jefferson, New Market, and Frederick City, and both fire and EMS units from Junior Fire Company No. 2 Inc. of Frederick participated in this training exercise, which was hosted by the Junior Fire Company.

A close working relationship quickly developed between EMS and police officers in the treatment of the victims. All Frederick City police officers are trained as first responders, and those at the drill began initiating patient care after securing the scene. Patients were initially triaged and "flagged" with tape in keeping with the new Maryland triage plan. After additional EMS units arrived on location, the patients were treated and transported off-site.

With more EMS providers on the scene, the police shifted their concern from giving patient care to gathering evidence (guns and drugs had been found on the victims and bags of white powder had been found scattered on the playground). The close interagency interaction made both groups more aware of the roles and responsibilities of the other group as they worked side by side doing each other's job as well as their own.

Demystifying Sublanguage of Emergency Services

Seminar on CISD

The American Critical Incident Stress Foundation will sponsor a two-day advanced training seminar on critical incident stress debriefings and post-trauma syndromes, November 9-10, in Baltimore. Faculty will include Dr. Jeffrey T. Mitchell, Dr. George S. Everly, Jr., and others. For information, call Deborah Orandle or Jeffrey T. Mitchell at 301-461-6831.

Almost every business, profession, or hobby has its own specialized language; fire and emergency medical services are no exception. Newcomers to these fields may be mystified by expressions such as backdraft, barnburner, heat-and-blow, blood bucket, and eat smoke. Al Ward, a firefighter/CRT for the City of Cumberland, developed a glossary of fire and EMS terms to make communications easier.

As a member of MIEMSS critical incident stress debriefing (CISD) team, Mr. Ward perceived that some mental

health professionals were struggling with the "sublanguage" of emergency services. With the help of colleagues, he collected terms and slang used every day by those in the field.

He hopes that "media representatives or anyone else who needs to know these terms will find the glossary entertaining and informative. I welcome any submissions for inclusion in future editions." For further information about the glossary, call Al Ward at 301-777-3441, or write to him at 607 Lynn Street, Cumberland, MD 21502.



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New Helipad Officially Open at PGHMC

Peninsula General Hospital Medical Center (PGHMC) officially opened its new heliport with a ribbon-cutting ceremony on July 28. To mark this special occasion, a new Maryland State Police (MSP) Aerospatiale 365 N-1 Dauphin 2 helicopter landed on the new heliport prior to the ribbon-cutting and was open for tours for members of the press, hospital and local government officials, and other guests immediately following the ceremony.

As part of the statewide EMS system, MSP helicopters sometimes fly patients who have been stabilized at Peninsula General to the MIEMSS Shock Trauma Center in Baltimore. Patients are flown to Baltimore if a greater number of trauma patients than Peninsula General can accommodate need treatment at any one time, or for certain types of injuries such as severe burns, pediatric trauma, spine injuries, or severe head injuries.

Peninsula General's new heliport is located on the south side of the hospital near the corner of Huston Terrace and West Locust Street. This one-story building straddles the ambulance entrance to the emergency department. Transport of the 300



Cutting the ribbon to officially open the new heliport at PGHMC are (l-r): Robert T. Adkins, MD (Chief of the Emergency Department at PGHMC and Medical Director of Maryland EMS Region IV); James W. Isaacs, MD (Director of Trauma Services and Ass't Chief, Emergency Dept.); Linda Gray, RN (Clinical Manager, Emergency Department); Kathy Frick, RN (EMS Liaison); Capt. Forrest Meeks (Commander, Aviation Division, Maryland State Police); Fulton P. Jeffers (Chairman, PGHMC Board of Trustees); W. Paul Martin (Mayor, City of Salisbury); Philip Foster (Delegate from Talbot and Caroline counties); State Sen. Lewis Riley; Henry Parker (President, Wicomico County Council); and John B. Stevens (President, PGHMC).

critically ill patients to and from Peninsula General by helicopter each year can be done quickly and safely, since the heliport is located about 200 feet from the emergency department.

The weight capacity of the heliport is 15,000 pounds. This is a 50 percent increase over the weight capacity of the former helipad on the roof of the

hospital's East Tower. This weight limit is also far greater than needed for the nearly 10,000-pound Dauphin 2, which is scheduled to replace the current Bell Jet Ranger on Maryland's Eastern Shore sometime this fall.

Peninsula General serves as the designated areawide trauma center for portions of Maryland EMS Region IV.