

New EMS Leadership Team at MIEMSS

Director of MIEMSS Kimball I. Maull, MD, announced changes in the leadership team of Maryland's EMS system on August 27.

Dr. Maull has appointed Richard L. Alcorta, MD, as acting state EMS director and J. Alex Haller, Jr., MD, as associate EMS medical director for children's programs. In addition, Dr. Maull said Douglas Floccare, MD, will continue as associate EMS medical director for Med-Evac and as Maryland State Aeromedical Director.

A search committee—comprised of representatives from Maryland's

Below we focus on the background of the two newest MIEMSS appointees, Dr. Alcorta and Dr. Haller.

An emergency physician and paramedic liaison at Suburban Hospital since 1987, and chairman of the Region V EMS Advisory Council for the past two years, Dr. Alcorta already has made major contributions to the state EMS system. He will now be in charge of coordinating EMS with federal, state, and county governments; he will oversee prehospital training and certification, research, and communications, as well as regional

both urban (San Diego) and rural (Imperial Valley) settings. In Imperial Valley, he also volunteered as a sheriff reserve for 2½ years and worked in a hospital ICU as a paramedic. He graduated with honors from Howard University School of Medicine in three years and did his internship and residency in emergency medicine at Harbor UCLA in California. While there he taught in the paramedic training institute, continued ride-alongs with ambulance medics, and completed a base station course.

In addition to his work as an emergency physician at the Johns Hopkins Hospital and currently at Suburban Hospital, Dr. Alcorta has been active in Maryland EMS in the areas of education, prevention, advocacy, and coordination.

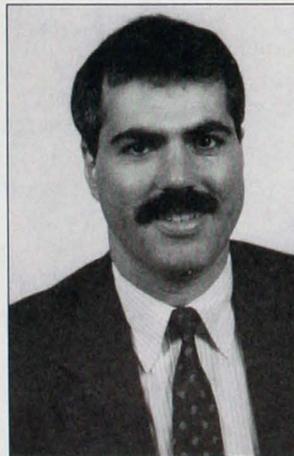
As an educator, Dr. Alcorta has given hundreds of hours of training in CRT, EMT-P, and continuing education programs in Montgomery County and has spoken at many prehospital care conferences around the state, including EMS Care, Parascope, Pyramid, Promoting Excellence in EMS, and Vital Signs.

Dr. Alcorta speaks of his involvement in prehospital training as an "effort to give back to paramedics what physicians gave to me when I was a paramedic."

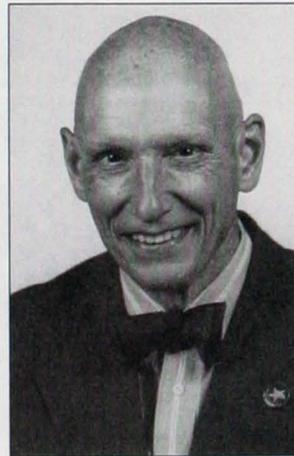
Dr. Alcorta also recognizes the need for specialized training for EMS personnel. He completed the level I hazardous materials course in Maryland and was the physician for the cave-in rescue team in Montgomery County, which through his support received DMAT designation.



Dr. Alcorta



Dr. Floccare



Dr. Haller

emergency medicine community—is being formed to select a permanent state EMS director.

"Maryland's emergency care system is only as good as each of its components," Dr. Maull said. "With the advice of our partners in EMS, we will select a new EMS director who will meet the challenge of once again moving Maryland's EMS system to the forefront nationally and internationally."

and educational programs related to EMS.

Dr. Alcorta is no stranger to the concerns of the prehospital care community—having started his medical career as an EMT-A, worked as a paramedic, and become an emergency medicine physician who is also involved in prehospital training.

Originally from California, Dr. Alcorta worked there as a paramedic in

Setting the Course

As many of you know, my initial intention as the new MIEMSS director was to take six months or so to listen to those who make the system work and to learn of the system's strengths and to determine areas needing improvement. I will tell you up front that I arrived with great expectations. My exposure to Dr. Cowley was always positive and I greatly admire his accomplishments. He set the course and saw it through.

I visited every region in Maryland, and my first priority was to learn from those providing hands-on care—the EMTs, CRTs, and paramedics. And learn I did. I learned of the commitment of thousands of men and women to doing what is best for their patients. I learned of a well-coordinated system with a statewide communications capability that remains a model for the rest of the country. I learned of the pride of belonging to a singular group—Maryland EMS—and knowing that our mission is one we can all feel good about. I learned of the generous support of our governor and state legislators for providing the best in EMS; even when fiscal pressures were almost unbearable, support for EMS remained a priority. And then I looked beyond Maryland and realized that much more needed to be done—and I asked questions that needed asking a long time ago.

Why is advanced life support defined by the CRT—a training identity unique to Maryland? Why has paramedic education not kept pace with ALS needs and why are many of our best trained paramedics leaving the state? Why is it that a paramedic can run as a paramedic in one jurisdiction and not in another? Why is the esophageal obturator airway (EOA)—already discarded as outdated and even dangerous by most states—still the airway of choice in Maryland? (See article on pages 4-5.) Why is it that individuals with real training and CME needs cannot get accurate and timely information back from the system that they support? Why is medical control provided by physicians at one hospital when the patient is taken to another hospital? Is this really best for the patient? What has happened to the concept "continuum of care"? Why do we have to "pilot" interventions that have already been proven useful in other states? Why is Baltimore the only city among the 25 most populous cities where you cannot be intubated in the field? Why indeed! And, lastly, why then has this system been packaged to the public as "the best in the world"? Have we become victims of our own marketing?

The answers to these questions may appear complex, but there is a

common thread among them—a lack of leadership. The EMS system has been described to me as a misnomer—it should be the EPS—emergency "political" system. It is politics—the promotion or protection of vested interests—that has sapped the strength of EMS and prevented Maryland from keeping up with advances in prehospital care. Political decisions have no place in EMS because they make the bona fide needs of patients secondary concerns.

I have not finished listening or learning—I hope I shall always do both—but I am ready to move forward. The recent changes in EMS leadership and new initiatives described in this newsletter provide an initial indication of this new direction.

Clearly, there is much to be done. The course is now set. From what I've seen across the state, the team is there to do it. EMS has many partners with a common purpose and agenda. There is reason to work collaboratively to provide what is best for our patients. Let's face it—if we provide the best EMS care, we will no longer have need for marketing.

◆ *Kimball I. Maull, MD*
Director, MIEMSS

Feedback on Patients

Have you ever wondered what happened to the patient you transported to the MIEMSS Shock Trauma Center? Information is currently available only to prehospital care providers Monday through Friday, from 8 am to 4 pm, by calling Karen S. Parkison, RN at 1-800-528-1732.

By November, other resources for getting this information will also be available. Ms. Parkison is also coordinating the Field Feedback Program, a component of the EMS Outcomes Management System, which will provide patient follow-up in *written* format statewide by November. (Be on the lookout for a new notebook and forms to arrive at your station.)

Prehospital providers will be able to follow up on patients they transport to MIEMSS Shock Trauma Center by checking either the notebook at their station or by calling their local MIEMSS regional office or local EMS office (both will have the same information that was provided to individual stations).

If you have any questions, contact Ms. Parkison at 1-800-528-1732.



Getting to know EMS providers and their concerns has been one of the priorities of Dr. Kimball Maull in his first months as the new director of MIEMSS. Shown here (l-r) are Councilwoman Joanne Parrott, Dr. Maull, Jim Lyons (president of Harford County Volunteer Ambulance Association), and Barry Woolf (EMS Chair of the Harford County EMS Committee) following a meeting with the Harford County EMS Committee at the Fallston Volunteer Fire and Ambulance Crossroads Station.

Saving Lives of Patients & Providers

Since the inception of EMS, prehospital care providers have worked diligently and tirelessly to save the lives of their patients. Due to the increasing incidence of infectious disease in the general population, however, the focus of saving lives is expanding to embrace the prehospital provider.

This past spring and summer, EMS managers and prehospital providers across the state have been preparing to meet the requirements set forth in the U.S. Occupational Safety and Health Administration's (OSHA) "Occupational Exposure to Bloodborne Pathogens" (Final Rule, 29 CFR 1910.1030). This standard was released in the *Federal Register* on Friday, December 6, 1991.

Maryland's Occupational Safety and Health (MOSH) has adopted the federal standard with few modifications (for example, change in the implementation dates). Maryland's bloodborne pathogen standard can be found in the *Maryland Register* dated March 20, 1992, Vol. 19, Issue 6.

The new bloodborne pathogen standard ensures that those individuals with occupational exposure to blood or other potentially infectious materials are aware of their employer's exposure control plan, applicable engineering and work practice controls, availability of personal protective equipment, approved housekeeping practices, availability of Hepatitis B vaccination, and approved recordkeeping practices (1). The adoption of the new standard has raised several questions:

1. Are volunteers covered under the standards?

The answer to this question is still unclear. Because an employer-employee relationship does not exist, MOSH does not consider volunteers to be covered under the bloodborne pathogen standard and will not issue citations for non-compliance (2).

In an apparent conflict with this interpretation, a Maryland worker's compensations statute recognizes a volunteer EMS provider as an employee while performing services (3). An opinion analyzing this conflict has been solicited from the State Attorney General's Office. In the interim, MOSH highly recommends that volunteers comply with the bloodborne pathogen standard.

2. Is a volunteer company that employs part-time paid people required to meet the standard?

According to MOSH, wherever an employer-employee relationship exists, the employee must comply with the standard (2). This means that all paid employees with occupational exposure to blood or other potentially infectious materials must be trained in accordance with the standard, offered the opportunity to receive a Hepatitis B vaccination series, and adhere to the engineering and work controls and housekeeping practices approved by the employer.

3. How should bloods drawn in the field be handled?

The Department of Health and Mental Hygiene recommends that tubes of blood be placed in plastic bags labeled "biohazard" and sealed (4).

4. Are uniforms considered personal protective equipment (ppe)?

The standard defines "ppe" as "specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes *not* intended to function as protection against a hazard are *not* considered to be personal protective equipment" (5).

5. Are gowns required to be worn in the prehospital setting?

The bloodborne pathogen standard consists of both specification standards that detail specifically what is required and performance standards that dictate that goal but lend flexibility to the means with which to achieve that goal. The portion of the standard relative to gowns is a performance standard requiring protection against the anticipated exposure. "The type and characteristics will depend upon the task and degree of exposure anticipated" (6).

6. When does a field provider need to wear masks or eye protection?

According to the standard, "masks in combination with eye protection devices . . . shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated" (7).

7. Can food be carried on board the ambulance?

OSHA, hereafter referred to as "Agency," reviewed the testimony offered in response to the proposed standard and recognized that "circumstances could arise which would require employees to remain in ambulances for extended periods of time. It is not the Agency's intent to

prohibit these employees from eating or drinking during such extended periods. Therefore, eating and drinking in ambulance cabs is permitted under the final standard provided the employer has implemented procedures to permit employees to wash up and change contaminated clothing prior to entering the cab. In addition, employers must prohibit the consumption, handling, storage, and transport of food and drink in the rear of the vehicle. Such procedures ensure that patients and contaminated material remain in the rear area of the vehicle (behind the separating partition)" (8).

Since the bloodborne pathogen standard requires training at the outset and "at least annually thereafter" (9), MIEMSS is updating its infectious disease training program to incorporate elements of this standard. This training package will be available for use with basic EMT-A classes and continuing education programs.

Please note that the new standard does not address all areas of infection control or exposure, only those concerning bloodborne pathogens. Therefore, care should be taken not to overlook general infection control principles and practices when preparing and implementing a plan to comply with the bloodborne pathogen standard.

◆ Elizabeth Nachbar

Assistant Administrator, Region III

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- 29 CFR 1910.1030 (d) (3) (x) (1992).
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- 29 CFR 1910.1030 (g) (2) (ii) (C) (1992).

Airway Management in Maryland: Today and Tomorrow

History

The esophageal obturator airway (EOA) was designed in the mid-1970s to be a simple, easily placed airway to prevent aspiration and deliver oxygen to the unconscious, apneic adult patient with no gag reflex. The device did not go through the normal clinical trials and standards testing before it was placed in the field.

It was not until the mid - 1980s that retrospective and prospective studies were undertaken to evaluate the safety, effectiveness, and success of the EOA. The data showed that the EOA could provide adequate volumes of ventilation when used properly but had several significant complications and limitations (1 - 10). At this point, EMS systems throughout the nation started to look closely at their systems and started the transition to endotracheal intubation as the standard prehospital airway management technique (4). The EOA was no longer the airway of choice (1,3,4,6 - 10).

Maryland was the leader in prehospital care in the 1970s, the CRT being the most advanced and skilled prehospital care provider using the EOA for airway management. When the paramedic program came on-line, Anne Arundel County was the first jurisdiction in the state to voluntarily advance the care delivered in Maryland by giving EMT-Ps the option of using endotracheal intubation or the EOA. Throughout the state the standard airway for CRTs remained the EOA, and EMT-As were given the option of taking a special module for EOA certification. Currently Maryland and Delaware are the only two states where EMT-As are allowed to use the EOA. However, based on available Maryland data, the EOA is NOT the most commonly used airway for adult patients in respiratory/cardiac arrest.

Airway management is still at the very top of the ABCs, after scene safety (protecting the provider and the patient). Because the most important skill for all prehospital care providers is airway management, we must stress a technique that minimizes harm to the patient and provides optimal gas exchange. Endotracheal intubation remains the airway of choice.

Comparison

If placed properly with a tight mask seal, the EOA is an adequate airway and has probably saved lives. But the EOA is inserted blindly and has also accounted for many deaths (1-4,7,8,10). The standard oral airway or the nasopharyngeal airway does not have this risk (2,5) (Figures 1-2). The only advantage of the EOA over the oral or nasopharyngeal airways is a slight reduction in aspiration (17% overall) (2).

Both the EOA and the oral or nasopharyngeal airways require a good mask seal and require two hands to achieve effective ventilation (9). The EOA has only one mask size and thus cannot match all patients (Figure 3) (1 - 3,5,7,8). The oral or nasopharyngeal airways can be used with various masks to match patient's facial contours (Figure 4), thus improving the seal and the efficiency of oxygen delivery and carbon dioxide removal.

The EOA is contraindicated for patients with a gag reflex and for those with oropharyngeal or esophageal bleeding. Some studies have shown that significant trauma occurs in 8.5% to 10% of all EOA placements; multiple case studies have documented fatalities following unrecognized EOA placements in the trachea that completely obstructed the airway (2,4,7) (Figure 5). The EOA has a placement failure rate of about 12% to 18%. Additionally, its application is limited to patients within a finite range of heights—that is, 5 feet to 6¹/₂ feet (6,9). Therefore, prehospital care providers trained in and equipped with the EOA as the only airway management tool are left without definitive ventilation for the short adult, the very tall adult, the adolescent, the child, and the infant.

Airway Management Solution

The ultimate and optimal answer to the airway management problem is endotracheal intubation (1,3,6,7,9,10). This direct visualization technique allows upper airway obstructions to be cleared with the use of McGill forceps. These two combined skills—ventilation and airway clearance—can be applied to all ages, sizes, and shapes of patients with medical or traumatic conditions (1,3,6,7,9,10).

Endotracheal intubation provides

the best gas exchange and minimizes the risk of aspiration (1,3,6,7,9,10). The person ventilating can use both hands on the bag valve system and does not have to try to maintain a seal on the mask (1,9). The misplacement rate for the endotracheal tube (ET) is reported at about 5.3% (4). The success rate of ET placement by the average paramedic is 88% to 97% (6).

Training for endotracheal intubation requires 6 to 14 hours, depending on the training model and whether cadavers or live anesthetized patients are used. Adult and pediatric manikins are frequently more difficult to intubate than human patients, and many programs are using the manikin as the only training model (11,12). This streamlines instruction and provides proficiency standards for both adult and pediatric patients (11,12). For prehospital care providers who have not done any intubations in a prolonged period, a proficiency review on the manikins can keep skills at a heightened state.

Maryland Today and Tomorrow

The EOA recertification classes for EMT-As are being converted to the Airway Adjunct Enhancement Workshop, which will stress the use of the nasopharyngeal and oral airways, suction, proficient bag valve, and 40 liters per minute flow rate demand valve technique. There will not be any recertification of EMT-A EOA. The EOA will be off the basic life support units by July 1, 1994. (This date was determined by consensus of the EMS prehospital community after much discussion and planning.) And in the meantime, EOA use will be discouraged but allowed where ventilation cannot be provided by other means.

Use of the EOA by CRT/EMT-Paramedics will be phased out as the endotracheal intubation program progresses, pending authorization by the Regional Medical Directors and the Board of Physician Quality Assurance. CRTs will be able to remain EOA certified until they complete the endotracheal intubation module; but, again, use of the EOA is discouraged. The endotracheal intubation module will be the first module in the projected CRT - to - EMT-Paramedic transition and the phasing out of the CRT as a state standard. The transition of all

(Continued on page 5)

Figure 1

Standard Oral Airway

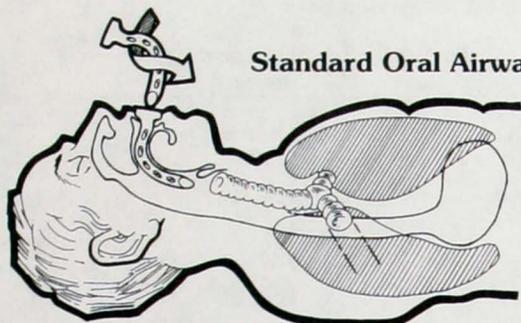
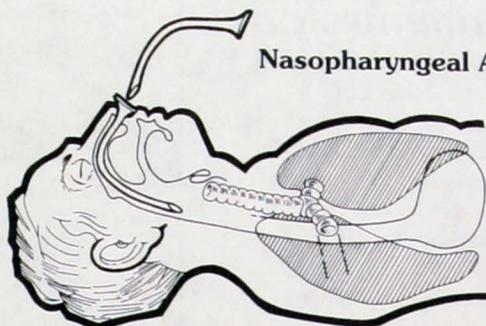


Figure 2

Nasopharyngeal Airway



(Continued from page 4)

CRTs to CRTs with ET skills could be completed within three years. The gradual transition of CRT to EMT-Paramedic will be accomplished through a modular program to meet the needs of the volunteer and through the college-training and fire-academy-based programs to meet the needs of the career provider. Both paths are demanding and will require dedication and commitment of both human and fiscal resources. The complete statewide transition of CRT to EMT-Paramedic with all national skill options could be available by the year 2000. In the meantime, however, as CRTs become EMT-P certified, they will be allowed to use all the ALS skills that they have been trained to perform within their jurisdiction, including endotracheal intubation.

The citizens of Maryland deserve the best. We aim to be the best.

◆ Richard L. Alcorta, MD
Acting State EMS Director

Figure 3

Esophageal Obturator Airway Correct Placement

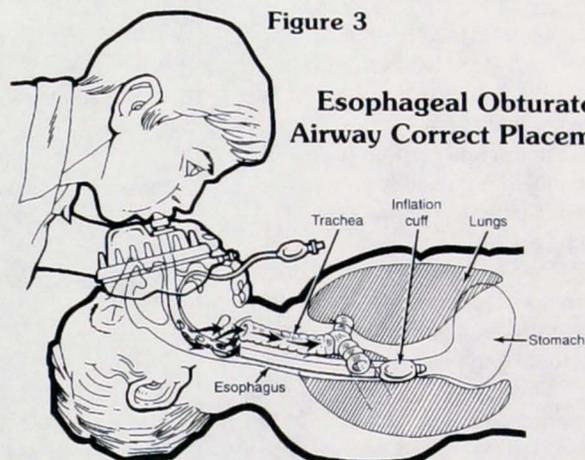


Figure 4

Multiple Masks for Good Seal

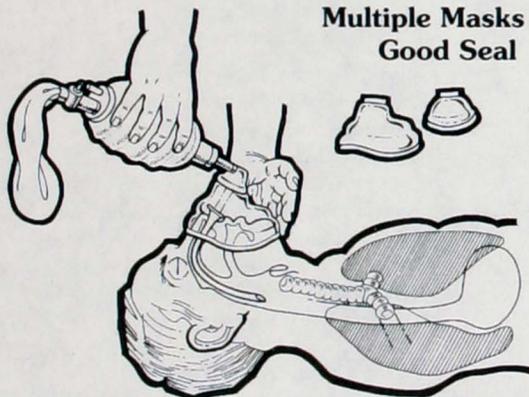
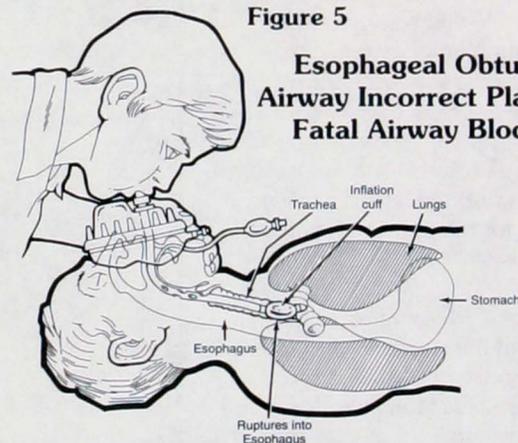


Figure 5

Esophageal Obturator Airway Incorrect Placement
Fatal Airway Blockage

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Governor Appoints EMS Commission

The Governor's Commission on Emergency Medical Services, established under an Executive Order in July, is scheduled to report its initial recommendations on a permanent governing structure for the EMS System by December 1, 1992.

James A. D'Orta, MD, an emergency physician at Franklin Square Hospital, and Nelson J. Sabatini, secretary of the Maryland Department of Health and Mental Hygiene, were named commission chairman and vice-chairman, respectively. (See box for listing of all commission members.)

The duties and responsibilities of the commission, quoted from the Governor's letter to commission members, are to:

1. "Develop recommendation for a governing structure for the System that provides clear accountability for management and performance.

2. "Develop recommendations for how emergency medical services in the State can best be utilized and delivered. Issues to be evaluated by the Commission include the delivery of services both in and outside of the State; privatization of aeromedical services; possible savings in the utilization of helicopter services for police work separate and apart from the medical evacuation service; the use and/or charges for the use of medevac helicopters for the transfer of patients between hospitals; and budgetary requests.

3. "Develop recommendations as to the role of the chief executive officer of the University of Maryland Medical System Hospital and the director of the Maryland Institute for Emergency Medical Services Systems in the distribution of patients within the hospital community.

4. "Upon approval of the governing structure for the System, function as an advisory board to the Governor on issues and matters referred by the Governor relating to the System and its operations."

Governor's Commission on EMS 14 Voting Members

Member Specified in Executive Order

Secretary of Department of Budget & Fiscal Planning (DBFP) or designee

Secretary of Department of Health & Mental Hygiene (DHMH) or designee

Superintendent of Maryland State Police (MSP) or designee

Representative from University of Maryland System (UMS) nominated by Board of Regents

Representative from MIEMSS nominated by the Director

Physician with experience and interest in EMS

Nurse with experience and interest in EMS

2 Citizens with interest and knowledge in EMS

Representative from State fire & rescue operations

Representative from American College of Emergency Physicians

3 Citizens at large

Representative from career fire and rescue services

Citizen with interest and knowledge in hospital administration

2 Interested citizens

Individual Named by Governor to the Commission

Charles L. Benton
Secretary, DBFP

Nelson J. Sabatini (commission vice-chairman)
Secretary, DHMH

Col. Larry W. Tolliver
Superintendent, MSP

Hon. Benjamin L. Brown
Member, UMS Board of Regents
Former Baltimore City Solicitor

Kimball I. Maull, MD
Director, MIEMSS

James A. D'Orta, MD (commission chairman)
Emergency Medicine Physician,
Franklin Square Hospital

Carol Ann Mays, RN
Emergency Department Nurse Manager,
Sinai Hospital

Willie C. Blair, MD
Traumatologist, Prince George's
Hospital Center and Suburban Hospital
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Fire & Rescue Services

Horace W. Murphy
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County Council of Baltimore County

Hon. Lawrence A. LaMotte
Maryland House of Delegates

MCISD Team Help Victims of Hurricane Andrew

When members of the Maryland critical incident stress debriefing (MCISD) team disembarked at Miami Airport and assembled at the Emergency Operations Center near Homestead on August 31, they didn't know what to expect.

Certainly the physical devastation caused by the 165-mph wind of Hurricane Andrew on August 24 was worse than they had imagined. Marge Epperson-SeBour, director of psychosocial services at MIEMSS and clinical director of the MCISD Program which is coordinated by MIEMSS, tried to describe it in terms that Marylanders could understand. "It was as if Catonsville, Essex, Dundalk, Towson, and surrounding areas had been leveled and left without any resources."

Despite the magnitude of devastation and tremendous physical loss of property and possessions that the population of Dade County faced, there was hope. The MCISD team found only a few incidences of clinical mental health illnesses. People were experiencing normal stress reactions such as crying and feeling overwhelmed, depressed, and indecisive; children were fussy and "acting out." And there were plenty of mental health professionals eager to offer their services; however, they were not readily identifiable and subsequently had few clients seeking their help.

So the task of the MCISD team became two-fold: to identify and coordinate existing mental health services and to work with and educate hurricane victims and workers so they could recognize stress symptoms. Ms. Epperson-SeBour set out to coordinate mental health services by centralizing and consolidating them. She formed a "management" team with representatives from six agencies. The other five MCISD members formed a "field" component, going to different shelters and hospitals to assess the needs of the victims and the resources available. They listened to and counseled both victims and relief workers and also conducted preventive crisis/stress education sessions. The "field" team also acted as the "eyes and ears" of the "management" team, relaying to "management" their assessment of the needs and available resources at the various shelters.

"Management," in turn, was trying



Widespread physical destruction, the aftermath of Hurricane Andrew, greeted MCISD workers.

to begin to coordinate services by linking various groups—the military, Red Cross, Veterans Administration, University of Miami Medical School Psychiatry Department, the Florida CISD team, and the Florida Human Resources Services/Mental Health Department (HRS/MHD). The goal was to centralize mental health services delivery through Florida's HRS/MHD.

Ms. Epperson-SeBour recalls that one agency had received more than 700 offers from mental health workers to volunteer their services. But the agency had no way to check their credentials or deploy them. A centralized mental health worker "pool system" was soon set up. The special needs of migrant workers, children, and the elderly were also addressed.

The field component of the MCISD team consisted of team leader Ogden Rogers (School of Social Work, University of Maryland Baltimore County), Ann Scanlon (Director of Psychiatric Nursing, University of Maryland Medical System), Dan Merlis (Chief of the Family Mental Health Clinic at the Veterans Administration Outpatient Clinic), Lee Ross (Psychology Professor, Frostburg State University), and Larry West (Associate Director for Basic Life Support Programs, MIEMSS).

They did "hands-on" interventions with approximately 2000 people in shelters and hospitals. They learned that many people with normal stress reactions were being given medications when, in fact, they needed only to be listened to and comforted. They also

trained social workers and psychologists to recognize stress symptoms and emphasized the need for "time out" for health-care providers to prevent burnout. (Many of the local medical staff and mental health providers were dealing not only with the stress of being relief workers in a disaster situation but with the stress of having had their own homes destroyed or severely damaged by the hurricane.) The goal of the MCISD field component was to have the medical community in Florida be able to provide the level of services needed during the aftermath of the hurricane.

The MCISD team had five days to accomplish its mission and team members feel they were successful. According to Ms. Epperson-SeBour, "Considering the magnitude of devastation in Southern Florida, there is an impressive and effective mental health response in the shelters and many communities. Ten days after the hurricane, a consolidated mental health effort was operative and coordination of service providers was initiated and implemented."

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DATED MATERIAL

New EMS Leadership Team at MIEMSS

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Dr. Alcorta is active at the county, regional, and state levels in accident prevention. He lobbied effectively for passage of Montgomery County's bicycle helmet law and is active with the Montgomery Chapter of the National Safe Kid's Coalition. With Montgomery County paramedic Capt. C. Edward Bickham, Dr. Alcorta developed a program on safe driving for high school students. Using slides of crashes and their victims, this program encourages young drivers to wear seatbelts and to not drink or use drugs and drive. Since 1987, Dr. Alcorta was a leader in the statewide effort to reinstate Maryland's motorcycle helmet law. This lifesaving legislation was passed by the General Assembly in 1992.

Dr. Alcorta also has been a member of various groups that coordinate emergency medical services, such as the Montgomery County EMS Advisory Council, the EMS Committees of the American College of Emergency Physicians and the Board of Physician Quality Assurance, and the Region V EMS Advisory Council, where he has served since 1988.

Experienced in many areas of EMS, Dr. Alcorta feels that "clearly the patient must come first, while the EMS provider is the next most important. And the EMS system works for both."

Dr. Haller is the Director of the

Children's Trauma Center at Johns Hopkins Hospital and a professor of surgery, pediatric surgery, pediatrics, and emergency medicine at Johns Hopkins University School of Medicine. He will lead Maryland's effort to improve its services to critically ill and injured children. Dr. Haller is nationally renowned in children's emergency care. "He will bring a new sense of purpose to improving our ability to respond to the special needs of injured and sick children," Dr. Maull commented.

Dr. Haller is an instructor on the national faculty for both the American College of Surgeons' Advanced Trauma Life Support (ATLS)[™] Course and the Advanced Pediatric Life Support Course for the American Academy of Pediatrics (AAP). He also is a member of the AAP's Committee on Pediatric Emergency Medicine and chairs the Maryland AAP Chapter's Committee on Pediatric Emergency Medicine. Dr. Haller is currently a member of the Task Force on EMSC (Emergency Medical Services Children) of the National Institute of Medicine, which is addressing the special needs of children in a comprehensive EMS System. He was past chairman of the American College of Surgeons' Maryland State Committee on Trauma, a position he held for five years. In this capacity he began the ATLS[™] course for the Maryland region with Roy Myers, MD, of MIEMSS; Dr. Haller was the first

director of ATLS[™]. He is also the current vice-president of the Pan-American Trauma Society. In addition, he is a member of more than 25 other surgical, pediatric, and medical organizations.

Dr. Haller, who received his undergraduate degree from Vanderbilt University and his medical degree from the Johns Hopkins University School of Medicine, has received numerous awards nationally and internationally. He is an active researcher and has written and published extensively. He is currently on the editorial boards of *Pediatrics*, *American Surgeon*, and *Journal of Trauma*.

"Dr. Haller brings to the post a life-long commitment to caring for critically ill children," Dr. Maull said. "This children's initiative--the first of its kind in the nation--will assure the best EMS for Maryland's future--its young citizens."

STC Case Reviews

All field providers are invited to attend Shock Trauma Center case review sessions normally held the fourth Wednesday of each month from 7 to 9 pm at the Shock Trauma Auditorium. Because of upcoming holidays, however, the next case reviews will be presented Tuesday, November 24 and Wednesday, December 16. Continuing education credits are available. For information, contact Elizabeth Nachbar, 410-706-3996.