Maryland
E·M·S
NEWSLETTER

Vol. 16, No. 1 | For All Emergency Medical Care Providers | July 1989

Interagency Cooperation: Key to Maritime Disaster Drill

As medics tend to patient needs, additional rescuers came on board to assist in the response. Within 25 minutes of the first call for help, 15 rescue boats were on the scene.

Personnel from various agencies worked together in the response to this mass casualty incident.

The call came at 11:08 hours: "Mayday! Mayday! Annapolitan II has collided with the Independence! Passengers are injured! One ship is on fire!"

The ensuing multiagency response was a maritime disaster exercise planned by the Marine Emergency Response Committee. That group was spawned in 1988 by communications between the Maryland Natural Resources Police (NRP) and the Anne Arundel County Fire Department. Recognizing the volume of maritime traffic in the county, those agencies had become aware of the need to train emergency responders in the special requirements of marine mass casualty incidents. Their first drill was held on April 28 in the Chesapeake Bay near Sandy Point State Park.

In this scenario, the Annapolitan II, a harbor cruise vessel operated by Chesapeake Marine Tours, was carrying 47 passengers and crew members. About 2½ miles north of the Sandy Point beach lighthouse, the tour boat collided with the Independence, a yacht (owned by Gov. William Donald Schaefer's office) that was simulating a shipping vessel for this drill. Most of the cruise ship passengers (students from UMBC's Emergency Health Services Program and NRP cadets) were injured. The "shipping vessel" was on fire and barrels of hazardous material on board were damaged in the collision.

Approximately 7 minutes after the call for help, the first rescuers — NRP officers — reached the scene. They were followed by emergency personnel from Anne Arundel County Fire

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Department, the US Coast Guard, and the Annapolis Fire Department.

Using the state's new triage plan, EMS personnel moved among the injured on the Annapolitan and assigned treatment/transport priorities. The rescuers assigned the task of moving patients strapped to backboards found that the steep, narrow stairways of tour boats were not designed for simple movement of immobilized patients. At 11:33 hours, the first patient was moved off the Annapolitan onto a smaller boat for the trip back to shore.

Simultaneous with the initial triage, a unified incident command was being established at the command post at Sandy Point State Park. Since many agencies have jurisdiction over the bay in the provision of emergency services, total cooperation was necessary to conduct a successful operation. All agencies involved had their on-scene commander report to the command post to ensure interagency coordination. The overall incident commander was Division Chief George F. Naegele of the Anne Arundel County Fire Department. All requests for services from one agency to another were routed through the command post. The EMS commander on the scene was Capt. Stu McNichol of the Anne Arundel County Fire Department. John Donohue, the MIEMSS incident commander, worked closely with him to coordinate the activities of the disposition and medical communications officers, the Go Team, and the critical incident stress debriefing team.

At Sandy Point beach, the secondary triage area had been set up in a parking lot next to the docks on the park's west side. Boats carrying patients pulled up to the dock and were met by litter carriers. Patients were carried or walked up to the triage area, where they were assessed and stabilized as necessary. Members of the state's critical incident stress debriefing team were also stationed in this area to monitor the psychological reactions of victims and care givers.

The transportation sector was just beyond secondary triage. Patients were assigned to waiting ambulances, and their destinations were logged into the tracking program, developed by MIEMSS, which runs on a portable computer (see article on page 7).

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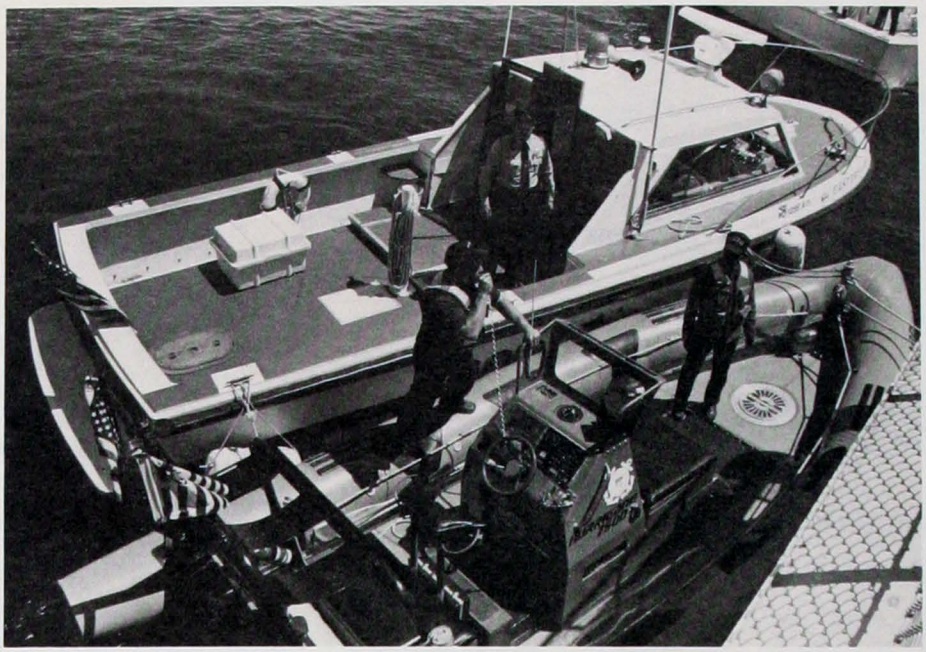

Personnel at the scene kept responders on shore informed of the number of passengers remaining on the tour boat and of needs for medical equipment.

On the way back to shore, medical attendants continued to monitor patients.

Patients were carried onto shore for assessment, stabilization, and transport.

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The Maryland State Police had two med-evac helicopters at the site: a Bell Jet Ranger and a Dauphin 2. In an actual emergency, the helicopters would have been used in search and rescue at the crash site in the bay as well as for patient transport from the state park.

Within 2½ hours, all victims had been transported from the crash site to shore, moved through second-stage triage, and assigned destinations from the transportation sector.

The primary objective of this training exercise was to test the effectiveness of interagency coordination during a maritime multicasualty incident. Representatives of the three agencies that have jurisdiction over the area where the emergency was staged agreed that the drill was successful.

Chief Roger Simonds of the EMS Division of Anne Arundel County Fire Department feels that "the drill proved that multiple agencies could interact and work together effectively. This is essential in any disaster management."

Maj. Franklin I. Woods, of the Natural Resources Police, noted that "the drill was excellent" from that agency's standpoint. "In regard to the response time to the scene, the time to transport all the patients to shore, and the cooperative work at the command post, we were quite pleased with the operations," he stated.

Following an evaluation of the drill in which Chief Simonds, Maj. Woods, and State EMS Director Ameen I. Ramzy, MD, participated, several "lessons learned" were identified.

1. The principles of initial triage should be reinforced to first responders. Their primary focus must be on gaining a quick assessment of the scope of the incident and assigning patient priorities, rather than administering patient care.

2. Private salvage companies could have been more involved in the response. Although the drill scenario did not call for the vessels to take on water, this danger could arise in a real emergency. The salvage companies could either stop the influx of water or tow the vessel to shallow water to prevent sinking.

3. A seriously burned, unconscious patient in the Annapolitan engine room was not found until about 1 hour after rescue operations began. This oversight underscores the importance of conducting an immediate, thorough search of the incident scene and accounting for all passengers.

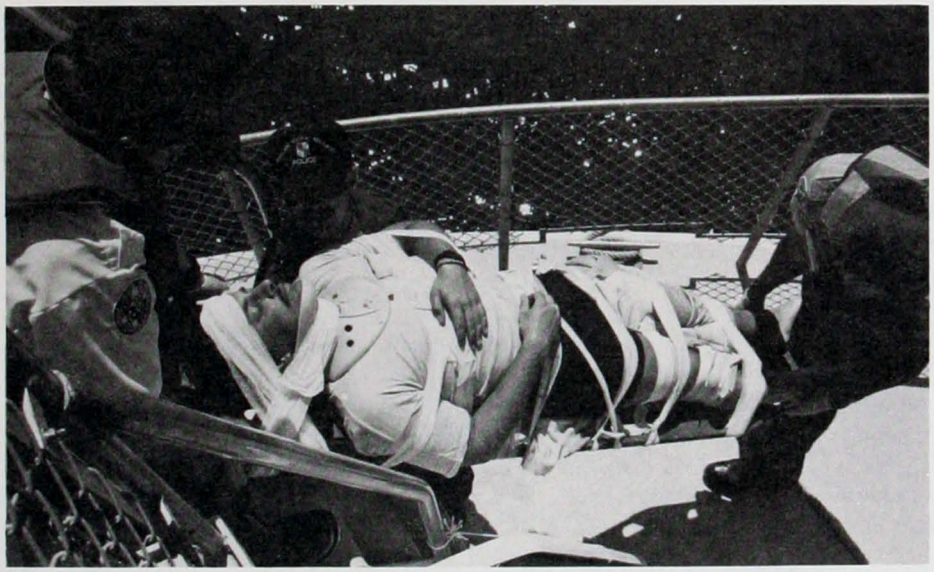
4. One-way flow of transport vehicles through the transportation area was not established. This is essential for proper disposition, medical communications, and patient tracking.

The day before the exercise, an educational seminar was presented for anyone who might be involved in the drill. Held at the Anne Arundel Community College, the day-long seminar covered topics such as shipboard firefighting, Maryland's new triage system, unified incident command, and marine search and rescue. A special presentation was given by Battalion Chief Allen Huelsenbeck on the shipboard fire to which the Wilmington, Delaware, Fire Department responded. No information specific to the Sandy Point drill was given; the organizers wanted personnel to respond as if a real emergency were occurring. All participants in the pre-drill seminar received continuing education credits.

A documentary of the exercise has been produced by United Cable TV of Annapolis. It is scheduled to air during the summer of 1989. Tapes are available from Capt. Steven Frye of the Anne Arundel County Fire Department and from the Region III office.

◆ *Linda Kesselring*

Capt. Steven K. Frye, EMT-P, Anne Arundel County Fire Department, and John Donohue, Region III administrator, assisted in the preparation of this article.



Narrow stairways on the Annapolitan II presented special challenges to rescuers as they carried patients on backboards.

Exercise Participants

Annapolis Fire Department
Annapolis Police Department
Anne Arundel Alarmers Association
Anne Arundel Community College
Anne Arundel County Fire Department
Association of Maryland Pilots
Chesapeake Marine Tours
Dana Cunningham Towing and Diving, Inc.
Governor Schaefer's Office
Maryland Department of the Environment
Maryland Department of Forest and Parks
Maryland Department of Natural Resources
Maryland Institute for Emergency Medical Services Systems
Maryland Natural Resources Police
Maryland State Police, Aviation Division
Seaview Marine Services
United Cable TV of Annapolis
United States Coast Guard
University of Maryland Baltimore County

Looking at Special Needs of Pediatric Trauma Patients

"Trauma is the leading fatal disease of childhood in America and in all the industrialized countries of the world," says J. Alex Haller, Jr., MD, director of the pediatric trauma unit at the Johns Hopkins Hospital, who spoke at the 11th National Trauma Symposium. "We have a responsibility to lead the way in combating this disease."

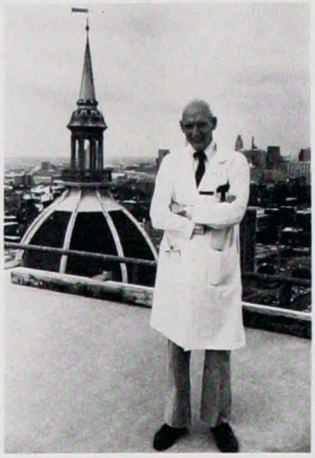
The types of injuries sustained by children under 12 years of age differ from the older population. Most children's injuries are motor vehicle related, but there are more who are pedestrians than passengers in vehicles. Forces brought to bear are therefore different. Pedestrians hit by vehicles rarely have extensive intraabdominal injuries requiring operative intervention, according to Dr. Haller. Teenagers' injury patterns are similar to those of adults.

Children involved in motor vehicle crashes as pedestrians sustain multisystem injuries. For example, a 2-year-old child standing next to his sibling's school bus fell under the bus wheels and became stuck to the exhaust system. He had blunt trauma, second- and third-degree burns over 30 percent of his body, crushing injuries to the pelvis and chest, tension pneumothorax, multiple pelvic fractures, bilateral femoral fractures, and an open fracture of the ankle.

A child with such injuries is likely to die if he does not reach the appropriate resuscitation center quickly. "That's why prehospital care is so important — to recognize where the child needs to be taken and to get him there quickly," Dr. Haller emphasizes.

"Then when the child gets to the hospital it's important to have physicians and nurses who are familiar with the resuscitation measures needed and who can proceed aggressively. This boy was in our emergency department (ED) in 20 minutes, was aggressively resuscitated, and left the hospital one month after injury with casts on various parts of his body."

Dr. Haller says, "Time is of the essence. The Golden Hour, the gospel learned from Dr. [R Adams] Cowley clearly documented that speed affects ultimate outcome. Over the past 10-15 years, we have learned that with children it is more like a platinum 20-30 minutes. There is not that much leeway. That is why the EMS system is so important for children."



Dr. Haller stands on the heliport of the Johns Hopkins Hospital.

It is remarkable that 88 percent of injured children were brought into the Johns Hopkins pediatric trauma unit from the field. When the unit began, the figure was 20 percent. This reflects the greater awareness on the part of prehospital care providers of the existence of the specialized care needed. According to Dr. Haller, a regionalized pediatric trauma center (such as at Hopkins and at the Children's Hospital National Medical Center in Washington, DC) should have the personnel needed to staff a readily available operating room, an intensive care unit for children, and intermediate care facilities.

One area that still needs to be developed is that of regional pediatric rehabilitation. This is addressed poorly throughout the country, Dr. Haller says.

Recommendations for prehospital and hospital care providers with pediatric patients include the following:

- Remember that children can develop hypothermia if they are exposed to the elements and lose their body temperature. They must be covered and protected, not only during transport but during examination. An air-conditioned ED can drop body temperature 2-3 degrees in 30-40 minutes unless there are overhead lights and heating to prevent it.
- The basic principles of pediatric injury management are no different from those of adults — the ABCs — but with the emphasis on airway.
- Children have always "just eaten." Assume that there is food in the stomach at all times, and there is usually some in the mouth. Be prepared to clear the airway.
- **Nasotracheal intubation is rarely recommended.** Oral intubation is the method of choice, maintaining the child's head in a central position so there won't be manipulation of the neck until you're certain that there is no cervical fracture.
- Cricothyroidotomy as an operative procedure is not recommended for young children, because the procedure will frequently destroy delicate anatomic structures in the laryngeal area — things are too small.
- Needle cricothyroidotomy is still appropriate as an insufflation technique if necessary. It is rarely indicated, Dr. Haller says, because an airway can usually be established. "We must constantly remind ourselves that the larynx is much farther anterior in a child's head than it is in an adult."
- Characteristics of the child's chest are somewhat different. The ribs are not yet calcified; there is a great deal of cartilage still in the child's chest. Therefore, flail segments resulting in fractures of the ribs are uncommon. However, there will frequently be a pneumothorax, because the rib may go down, go into the lung, and pop up without evidence of any rib injury. Intrathoracic injuries are not that common in children, but lung contusions are often seen.
- Taking the pulse is key in the initial examination, much more so than blood pressure. The pulse will never fool you. It always responds to losses in volume, and there is a change in quality and a speedup in rate. Skin color is also helpful in examination.
- Blood pressure is not as valuable a tool in the assessment of a child as it is in an adult.

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Dr. Haller checks James Reinoehl, one of his patients, in the pediatric intensive care unit.

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Children can maintain their blood pressure up to a 40 percent blood loss. Blood pressure in a child does not fall until the child is about to expire. The child's blood pressure will go down when there are signs of deep hypovolemic shock, but resuscitation must be started earlier. The basic principles are the same as for adults: Use crystalloid as a first line, with Ringer's lactate being the crystalloid of choice. Give 10-20cc per kilogram initially, repeating in 10-15 minutes or sooner if there is no response on the part of the vital signs. A double bolus of 20cc brings you to 40cc per kilogram. If the blood volume of the child is calculated at 90-100cc per kilogram, by the time you've given 20cc twice, you've given 40 percent of the blood volume.

"At this point, if there is no appropriate response, hang blood," Dr. Haller says.

- An ED involved with life-threatening injuries to children *must* have a CAT scan available by current standards, not only for head injury but because it is the best modality for documenting intraabdominal injury. The CAT scan area should be very close to the resuscitation area.
- If the child remains stable, with documented liver or spleen injury, the child is treated nonoperatively in the pediatric intensive care unit under close observation. If deterioration takes place, the child is taken to the operating room. This is *nonoperative*, not *nonsurgical*, management. There is a difference. It is a surgical decision not to operate. If the patient deteriorates, it is the surgeon who makes the decisions to operate; therefore, the surgeon must be intimately involved in the initial management and evaluation of the patient and should be constantly available in the monitoring of the child.
- ED personnel must become more aware of the battered child syndrome. There are usually early signs of neglect. Psychological changes in a child's reactions, such as being expressionless, whimpering, or being unusually fearful, or failure to thrive, can be hints of a first or second episode of abuse. Rarely is a child killed by the first episode of abuse; there are usually multiple episodes. It is important that initial evaluations by experienced personnel detect multiple fractures, both old and new, such as in the other arm or leg, as well as the present fracture. This detection may avoid mortality and make it possible to begin preventive measures in the home and environment of the child.

Dr. Haller points out: "My commitment as a surgeon and a parent is to injury control. Child restraints were introduced under the aegis of a pediatrician in Tennessee and had a significant effect on decreasing mortality. There is still much to be done. It takes cooperation between the schools, PTAs, and members of society with us, the professionals, to give the special kind of care children need. Those committed to this special care recognize the challenge."

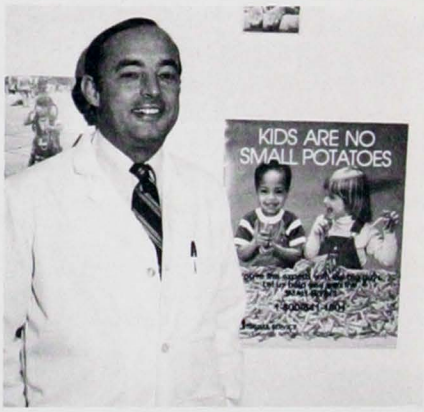
◆ *Erna Segal*

Training in Pediatric Care Needed

"Only 30 percent of designated children's hospitals in this country have emergency departments. Most children's hospitals focus on infectious diseases and cancer. But today more children die from injury than from infectious diseases; and cancer care is progressing well. We can't say the same about pediatric trauma care on a nationwide basis," says Martin R. Eichelberger, MD, director of emergency trauma services at the Children's Hospital National Medical Center in Washington, DC. Dr. Eichelberger spoke at the 11th National Trauma Symposium.

Fifty-thousand children, median age 7, are permanently disabled each year in this country due to injuries; 2 million are temporarily disabled. Most injuries are blunt injury, burns, or penetrating injury, in that order. Most of the injuries are related to motor vehicles, which cause 5-10 percent of children's mortalities. Falls also account for a significant number of deaths. Although assault and abuse of children result in only a small percentage of overall pediatric injuries, they are responsible for 22 percent of pediatric mortalities in the District of Columbia.

Dr. Eichelberger points out that the kinds of injuries that parents, babysitters, EMTs, nurses, and physicians should be trained to deal with are head injuries, orthopedic injuries, and abdominal/chest injuries (these result in 50, 40, and 5 percent of the total injuries, respectively).



Dr. Eichelberger stresses that children are not little adults. Special training is needed to handle pediatric injuries.

"With pediatric patients, the ABCs can be restated: Airway, airway, and airway," Dr. Eichelberger says. "Of course 'Breathing and Circulation' are important to the child, as to any patient, but without securing the airway you have a dead child." Become an expert in pediatric airway management, he emphasizes. "These are small areas to work in and fragile internal

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Pediatric Training Needed

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structures in a child's body. The wrong size cervical collar can cause a good airway to go bad. For a baby, a bag-mask is probably better than intubation. If you do not know what you are doing, you could have a child with no injury other than the one that you inflicted upon him."

The answer to this worrisome predicament is education. A training program was established at the Children's Hospital National Medical Center. The Pediatric Emergency Medical Services Training Program (PEMSTP) was a special project of regional and national significance within the Department of Health and Human Services Division of Maternal and Child Health. It was supported by the Department of Transportation. Federal funding is no longer available so Children's Hospital is continuing the program on a tuition basis.

PEMSTP's objective is to increase the knowledge of EMS instructors about the special needs of children with emergency medical and traumatic conditions. To date, 204 EMT-A and EMT-P instructors from all 50 states, the District of Columbia, Guam, and the Virgin Islands have attended the program. Course participants learn about children's unique anatomic and physiologic responses to illness and injury and are taught appropriate prehospital management of these conditions. They then return to their states and teach other EMS personnel what they learned during their 1-week course.

For further information about PEMSTP, call Jane Ball, 202-939-4927.

◆ *Erna Segal*

Pilot 'Nursing Extender' Program

Responding to the current shortage and the predicted shortage of nurses in the future and to the need to creatively use each nurse's skill to the greatest possible degree, the MIEMSS Shock Trauma Center implemented a series of 3-month pilot programs for nursing extenders.

The first program, which finished in July 1988, was felt to be successful in its use of six LPNs; four are still on the job. The second program, which will begin in October 1989, will consist of talented nursing assistants and attendants for Level 1 positions. There are tentative plans to use prehospital care providers for the third group, to function at least at Level 2. At the completion of these three programs, an evaluation will determine if the role of nursing extender is feasible at the Shock Trauma Center; the impact on the nurse partner; which kind of background or which mix of these groups will be most appropriate; and the impact on the quality of patient care.

In the following article, Virginia Cardona, MS, RN, CCRN, director of nursing education, who is responsible for the educational component for both the nurses and the nursing extenders, describes the nursing extender program, which is directed by Connie Walleck, MS, RN, CCRN, associate director of clinical practice, under the aegis of Elizabeth H. Scanlan, MS, RN, MIEMSS director of nursing.

Nursing extenders relieve the RN of tasks that do not require advanced nursing skills, such as making beds and feeding and bathing the patient; each nursing extender works under the supervision of an RN. Delegating routine work enables the senior RN to assess, monitor, analyze trends in vital functions, and perform technically demanding tasks, consult with families, teach patients, etc.

A task force was formed at MIEMSS to plan the implementation of the pilot program and to help determine the job description, salary, benefits, a method of evaluation, and career ladder development. It was decided that there should be two levels of nursing extenders. Salary ranges are $17,000 - $22,000 for Level 1 and $18,000 -$24,000 for Level 2.

Requirements for a Level 1 nursing extender are a high-school diploma or GED and either 2 years experience as a nursing assistant; or 1 year as a medical corpsman; or 1 year as an EMT; or being a new graduate of an LPN school. Direct patient-care duties of the Level 1 nursing extender include bed baths; shampoos; oral hygiene; turning positioning; feeding; making a bed; taking vital signs (documentation is limited to the flowsheet only, not providing narrative documentation); and assisting with admission histories, such as height and weight. Other duties are recording pertinent observations; assisting with routine dressings; and assisting the nurse in obtaining ABGs (arterial blood gases) and venous blood. CPR training is required in the event a patient suffers cardiac arrest.

Level 2 nursing extenders need a high-school diploma or GED and either 1 year as a Level 1 nursing extender; or 3 years as a medical corpsman; or at least 1 year of experience as an LPN; or 2 years as a trauma/transport technician (a position in the MIEMSS resuscitation area).

Level 2 nursing extenders perform all the duties of the first level, plus administering fever packs (a protocol of the Shock Trauma Center regarding blood studies when a patient runs a fever), nasogastric tube insertions, Foley catheter insertions, 12-lead ECG testing; balancing transducers; and drawing arterial and venous blood samples.

The task force decided that potential sources of nursing extenders include talented nursing assistants, medical corpsman, EMTs, LPNs, CRTs, paramedics, and trauma/transport technicians. Since the end of the first pilot program, the task force determined that LPNs are overqualified to be on the first level; they will now be promoted to the second level when they complete their probationary period.

"Delegation is the key factor," Ms. Cardona says. "And this is not taught in schools. If nurses do not know how to delegate, it won't work. Newly graduated nurses are not ready to delegate yet. Some want to be 'Supernurse'; others know they can't

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MIEMSS Develops Computerized Patient Tracking System

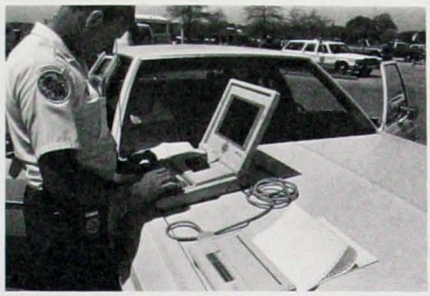
In any mass casualty incident, keeping track of the patient and his/her destination is a problem that is commonly identified. To assist in this process MIEMSS has developed a computerized patient tracking system.

Designed for an IBM or IBM-compatible computer, the patient tracking program will display a copy of the new Maryland triage/treatment tag. Anyone with minimal typing skills can easily transfer the information from the actual completed triage tags to the computer. Once the data are saved in the computer's memory, information on an individual patient can be displayed on the screen, or patient information can be displayed in list form. If the computer is attached to a printer, a printed listing of the patients and destinations can be produced.

In most mass casualty incidents, a single transportation sector is established, thus creating a single collection point for the top copy of the Maryland triage/treatment tag. The use of a single computer near this location will facilitate the information-gathering process which will generate a complete patient disposition list. In some incidents there might be multiple transportation sectors with each one creating a patient disposition list. The MIEMSS patient tracking program will make a "runners" disk at each computer station. This disk can be collected and taken to one central computer location to be merged into a single database file. This master file will then provide a complete listing of all patients entered into the system from the other locations.

The program will also allow a user to temporarily exit the program and enter a telecommunications program. Then the patient list can be transferred by telephone or cellular telephone to a central alarm, a hospital, or any other remote location having the need for the patient list.

To further support this telecommunication feature, MIEMSS operates a computer bulletin board. This bulletin board is a free service accessed by computer only at 301-328-3842.



During the recent maritime disaster drill, patients' destinations were logged into a portable computer by Ken Young of MIEMSS Office of Prehospital Training and Certification.

Additional information on this program can be obtained by contacting the MIEMSS Testing and Certification Office at 301-328-3666.

◆ *Ken Young*
Associate Director for Quality Assurance, Prehospital Training and Certification.

Workshop on Drunk Driving Recommendations Available

In the May 1989 issue of this newsletter, the Surgeon General's Workshop on Drunk Driving was highlighted. The recommendations from the workshop were announced at a press conference by Surgeon General C. Everett Koop on May 31, 1989. Free copies of the report (up to 5) can be obtained by writing to: National Clearinghouse for Alcohol and Drug Information, Department SG/DD, P.O. Box 2345, Rockville, MD 20852. Please indicate your organizational affiliation.

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Hearing Screenings Held

As part of "May Is Better Speech and Hearing Month," the Speech-Communication Disorders Program of Montebello Hospital and MIEMSS provided a community service by conducting their annual free hearing screenings on May 24. Over 250 people ranging from 2 to 87 years participated in the screenings. A hearing loss was identified in 72 percent of the participants, all of whom received information and locations for follow-up evaluations.

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EMS Week 1989

EMS Week will be celebrated September 17-23 and will focus on the theme "The Maryland EMS Team: Ensuring Your Future." The EMS awards banquet will be held at the Engineers Club on September 21. For further information, contact your regional administrator.

Canadian Medical Assoc. Annual Meeting Slated

The Canadian Medical Association's Annual Meeting Scientific Program will be held August 23-25, 1989 in Quebec City. The program will focus on vehicular trauma and trauma care. The keynote address will be given by Donald D.Trunkey, MD, from Oregon. For information, contact Marie Claire Bedard, CMA Meetings Dept., P.O. Box/C.P. 8650, 1867 Alta Vista, Ottawa, Canada K1G0G8, Phone 613-731-9331.

◆

Region IV Conference

Region IV EMTs and CRTs should mark their calendars for Saturday and Sunday, September 23 and 24, 1989. The Region IV office, the Caroline County Advanced Life Support Services, and the Memorial Hospital at Easton are planning a two-day continuing education program to be held at the Memorial Hospital. Those who attend both days of classes will be eligible for 12 hours of continuing education credits to meet their recertification requirements. The conference will conclude the EMS Week activities. A complete program schedule and registration information will be published in the August issue of the *Maryland EMS Newsletter.*

Pilot 'Nursing Extender' Program at STC

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be. The latter is the target group we work with." RNs delegate and manage the nursing extenders; this establishes trust in the partnership.

"Some nurses are afraid having a nursing extender would diminish their role; it doesn't, it helps them to achieve. It doesn't affect primary nursing if it is done correctly."

On-the-job education for the nursing extender included 9 days of preparation by pre- and post-tests; instruction on technical equipment, such as the Stryker frame; and 27 self-teaching modules. Clinical orientation included 4 weeks with a preceptor/nurse partner.

Advantages of the nursing extender to the senior RN include:

- More flexibility: The RN can delegate and use the time saved to do other tasks.
- Efficiency: Using nursing extenders as an additional resource, the RN can take care of the more critically ill patients.
- Motivation: Nursing extenders relieve the routine and give the RN increased mobility.
- More staff resources.

The nursing extender is an alternative hospital staff support for providing direct patient care at a time when the patient acuity is high, resulting in increasing care demands in the face of a national nursing shortage which is predicted to continue into the 1990s.

New VP of UHMS

Roy A.M. Myers, MD, MIEMSS director of hyperbaric medicine, was elected vice-president of the Undersea and Hyperbaric Medical Society at its annual meeting in June.

Helicopter Update

Meeting June 12, the Maryland Executive Helicopter Advisory Committee (MEHAC) approved the purchase of three Aerospatiale, 365 N-1 Dauphin 2 helicopters in addition to the six already on order. These additional helicopters are needed to provide coverage for six bases as well as coverage if an aircraft is grounded for maintenance, for training purposes, and in the event of unexpected breakdowns.

MEHAC also decide on six permanent bases that would use the Dauphin 2. These bases will be located at Cumberland, Frederick, Andrews Air Force Base (pending Air Force approval for donating land for construction of a state hangar), Martin's Airport, and Salisbury. A new base is planned for Norwood, in Montgomery County.

Responding to concerns from southern Maryland and the Eastern Shore regarding the possible closing of helicopter bases at Patuxent Naval Air Station and Centreville, MEHAC decided that the two bases would remain open at least until July 1, 1991, equipped with the Bell Jet Ranger helicopters now in use. In the fall 1990, MEHAC will review data on the use of these bases to determine whether they should be kept operational or if service can be provided from other bases.

Published Monthly

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for
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Address Correction Requested
MIEMSS, *Maryland EMS News,*
22 S. Greene St., Baltimore, MD 21201-1595

DATED MATERIAL