Nightmare in Kansas City

On Thursday, July 16, editors at ***jems*** talked with EMS officials in Kansas City about an article we were preparing concerning changes and adjustments their system was experiencing as it evolved into a full-fledged public utility. The next day we heard the news along with everyone else in the country: tons of metal and concrete had fallen onto a crowded dance floor at the Kansas City Hyatt Hotel, killing and injuring hundreds. The magnitude of the disaster presented Kansas City with one of the greatest challenges yet to face a modern EMS program. We were back in touch with people in Kansas City, and they agreed to prepare the following accounts of the emergency response.

Jack L. Stout is president and senior consultant with The Fourth Party, Inc. Stout has been active in EMS developments for almost ten years. As developer, along with former partner, Alan Jameson, of the Public Utility Model, Stout's concepts and consulting work, often the subject of controversy, are a significant force shaping the legal, financial, administrative, and operational future of the prehospital care industry. Mr. Stout was on the scene at the Hyatt disaster.

Patrick Smith is a project manager with The Fourth Party, Inc., and is currently on loan to Kansas City's Metropolitan Ambulance Services Trust (MAST) as acting assistant director. Smith has worked eight years as a field paramedic, with one and one-half years as manager of a private countrywide ambulance service. Now with The Fourth Party, Smith concentrates on EMS operations, including medical protocol development, disaster protocol development, computer-aided dispatching, communications, medical audit, and operations problem-solving. At the Hyatt disaster, he provided coordination among the several areas of activity, executed a number of essential support projects throughout the night, and assisted in patient care and rescue efforts.

It's been a week now since we agreed to write this article. We finished pulling together the facts a couple of days ago, and we've been trying to get started ever since. Something's wrong.

We would like to write an objective and professional sounding article telling what happened, how our system responded, what we did right, and what we learned from the experience that will enable us to perform better in the future. And, we're going to try to do that. But before we try, we must admit something. We are not objective. We don't feel professional. We've been changed and we're not sure how.

It is important that we all learn from this event, because our learning is the only good thing that can come out of that awful and stupid tragedy. But there's more to be learned here than systems and procedures. Something very powerful has happened to us — to our entire community — and it's not over yet.

So, we'll do our best to tell what happened, what worked, and how we might improve our performance for the future. But we must warn the reader that this account, however it may sound, should be considered subjective and personal. Since that night, one of us has discovered that he is now afraid on airplanes; and our dreams are bizarre.

One final introductory note: From time to time throughout this report, we shall identify certain people by name. We thought a great deal about the problem of recognizing some individuals by name, while not recog-

by Jack Stout and Patrick Smith

nizing others. We have decided to describe events of importance to EMS personnel everywhere and, where an individual known to us played a prominent role in that event, we have named the individual. There were real heros in Kansas City that night. Lots of them. A great many of their names are not included in this report.

Background of KC EMS System

At the time of the Hyatt disaster, the Kansas City EMS System was smack in the middle of converting to the Public Utility EMS Management Model. The system had been undergoing the stresses and strains of massive organizational change for over a year. We had just completed financial arrangements for a $2.5 million lease to replace nearly all the equipment in the system — vehicles and communications, but the new equipment had not arrived. We weren't exactly caught with our pants down, but maybe we were zipping them up. In any case, the progress that had been made was felt that night.

For example, the City's five private ambulance companies had already merged into a single contracted provider organization — Ambulance Services Incorporated (ASI). What was previously a "two-tiered" system of BLS/ALS response had already been converted to a one hundred percent ALS system. Every dollar of income into the ambulance industry in Kansas City, Missouri, whether from fees for service or city subsidy, goes to support advanced life support production capacity. For that reason, all 14 ambulance units on duty at 7:08 p.m. that Friday night were equipped and staffed for advanced life support.

Another change that had been previously completed was the full consolidation of ambulance dispatching. In August of 1980, less than a year before the disaster, all ambulance dispatching, emergency and nonemergency, was consolidated into a single dispatch facility, bringing every ambulance in the City, whether on emergency or nonemergency business, under the routine control of a single dispatch center.

A formal in-service training program had also been initiated by ASI's Doug Klote. The in-service training program had already begun to address disaster protocols. The system's disaster readiness had been tested in recent weeks by two smaller scale fire-related disasters involving multiple critical casualties.

Only weeks before the Hyatt Disaster, ASI's Jack Morasch had taken control of ASI's dispatch operations. Metropolitan Ambulance Services Trust (MAST), a public trust established by the City to oversee ambulance operations, had recently become critical of the lack of progress in improving dispatching operations, and ASI's owners had responded by putting Paramedic and former Dispatcher Jack Morasch in charge. Morasch had made more progress in a few weeks than had been made since the dispatch consolidation some ten months before. In fact, Morasch had completed disaster orientation of his dispatchers only days before the tragedy occurred.

Even the City Health Department's ambulance inspection program contributed. Only a few days before the Hyatt Disaster, Health Department Inspector Amy Kinney had discovered a breakdown in ASI's inventory control procedure, and ASI's management had responded by substantially beefing up on-board supply inventories as well as its internal procedures for ensuring compliance with system standards. (In fact, as EMT Gary Frank stripped ambulances of supplies that night, he actually thought about the recent Health Department inspections and the controversy they had caused.)

Bringing about large-scale organizational change in the EMS industry is almost always a difficult and controversial process. In Kansas City's case, the problem has been compounded by: the merger of several small companies into one large ambulance firm; legal entanglements including a lawsuit which may test the very foundation of the Public Utility approach; changeover to a new "System Status Management Plan" which varies the number of vehicles on the streets by time of day and day of week, and which utilizes shifting ambulance "post" locations to meet anticipated changes in demand; and the sheer complexity of the model being implemented.

Perhaps as important as anything that night was the caliber of the people in the EMS system. Over the past year or so, several forces combined to begin to upgrade the professional quality of personnel.

14 Hours—A Summary

7:08 PM — Four calls are received within four minutes from the general public. The requests are for ambulances at the Hyatt Regency, and the callers report that part of the lobby fell in, possibly part of the ceiling. Calls indicate that at least 100 people must be hurt.

7:09 PM — Ambulance Unit 110 starts en route to the scene, manned by Supervisor Allen Askren and Steve Thomas. Throughout the evening, Askren would coordinate the outside triage area and patient transportation, and Steve Thomas would become the communications officer at the scene.

7:10 PM — Ambulance 105 starts to the scene.

7:11 PM — Ambulance 110 requests two more ambulances, and Unit 144 and Unit 109 start en route to the scene from two separate fire stations.

7:12 PM — Four minutes after the first call, Ambulance 105 is on the scene and headed inside. Unit 901 is also approaching and asking who the triage officer will be. The information is given that the field supervisor on Unit 110 will be responsible.

7:15 PM — Ambulance 110 arrives at the scene along with Unit 144.

7:16 PM — Approximately eight minutes after the disaster, Ambulance 901 advises they have an emergency physician on board, Dr. Steve Orr, an emergency physician at Truman Medical Center who had recently become active in the Emergency Physician Foundation (EPF). (In Kansas City, the EPF clinical leadership and medical supervision are under contract to the city Health Department. Dr. Orr was riding as an observer on 901 that night.) Unit 105 advises 901 they need Dr. Orr inside.

7:17 PM — Ambulance 110 advises that the command post has been set up at the intersection of Pershing and McGee, and requests four more ambulances to the scene. Ambulances 113, 501, and 101 are dispatched from three separate locations. The fourth ambulance is en route.

RECAP first ten minutes — Within the first ten minutes, four calls have been received from the general public, numerous calls from fire department and police department personnel

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ASI's relatively high wages have attracted some very good people. Just as significantly, those wages have helped to retain personnel who might otherwise have bailed out during all the recent change and controversy. The Emergency Physician Foundation's (EPF) medical audit process, the new in-service training requirements for City certification, the mandatory upgrading of intermediate level ALS people to full paramedic status, the training requirements for dispatchers, the pre-instruction screening standards and strong academic requirements of Ed Voss' training programs at Penn Valley Junior College (a joint effort by Penn Valley, ASI, the EPF, and MAST, tailored to Kansas City's training needs), the increasing formalization of standards, procedures and accountability, not to mention the increased productivity, loss of on-the-job sleep time, and sometimes unpopular shift schedules resulting from the "system status management" approach to response time control...all of these changes were and still are making Kansas City's EMS system an increasingly uncomfortable place for the old time "ambulance jock," however credentialed, and a more interesting place for the true professional. (As this article goes to press, plans are being finalized to overhaul ASI's entire middle and top management structure — a move which will further professionalize the company.) There are extremely capable people working streets and dispatch in Kansas City, and quality continues to improve. Their performance at the Hyatt disaster was no accident.

Fourteen Hours

Nothing we write in this report can describe what happened. The personal accounts provided by EMT Gary Frank and Paramedic Jim Taylor may help the reader gain a better feel for what went on. We were there, and except for occasional flashes of comprehension, we can't get a handle on it ourselves. That maybe just as well. We reconstructed the events in the accompanying description, "14 hours—A Summary."

What Worked Best and Why

In order to discuss what worked and why, it is probably important to get a general feeling for just how well the whole thing was handled. How good was the response in Kansas City? It was damned near perfect.

Ms. Joanne McGlown, a consultant with the Division of Emergency Medical Services for the U.S. Fire Administration, and Captain Howard Lavert of the Seattle Fire Department, also a Fire Administration consultant, recently investigated response to the Kansas City Hyatt disaster. Ms. McGlown said she and Lavert agreed: "What we saw in Kansas City was probably one of the most successful disaster responses we have ever seen."

Ms. McGlown said that information collected in Kansas City may be useful for teaching fire services all over the country. According to Ms. McGlown, "There were a lot of unique aspects of that disaster that probably would have overwhelmed emergency services in a lot of cities, but in Kansas City it did not."

Wes Powell, Division Chief and EMS Coordinator for the Phoenix Fire Department said, "Given the situation at hand, I can't think of anything that could have been done that wasn't done. It was a horrendous situation. I don't think the actions taken by the Kansas City Fire Department, Ambulance Services Inc., or anyone else involved contributed to the morbidity or deaths of any patients. They rescued those they could rescue, given the situation."

So, a lot of things worked well. We agree. Think about it: Take a tea dance packed with people at a plush new hotel. Then add the terror of tons of concrete and steel crushing and mangling 300 people, leaving bodies and parts of bodies, some unrecognizable, in the midst of hundreds of relatives, friends, and bystanders. Then add broken water pipes flooding the area, and broken gas pipes threatening additional disaster.

Then, in about ten minutes there are seven paramedic ambulance units on the scene, fire department personnel, police, an emergency physician, and more of everything on the way. Within a half an hour, more than twice that many ambulance units are on the scene, the fire department's extrication efforts are going full tilt, heavier equipment is being called in, area hospitals are gearing up, off-duty ambulance personnel are on the way to the scene, mutual aid responders are covering the rest of the City, the outside triage area is starting to function

Shown is a critical moment in the extrication process. The tilted catwalk at left has been secured with an additional crane (not shown) while two cranes, jammed through the windows in the lobby's front wall, begin to raise the first of several sections of catwalk. Victims trapped between the floor and the bottom catwalk could obviously not be dealt with until the upper sections were removed.

Photo courtesy of the K.C. Fire Department

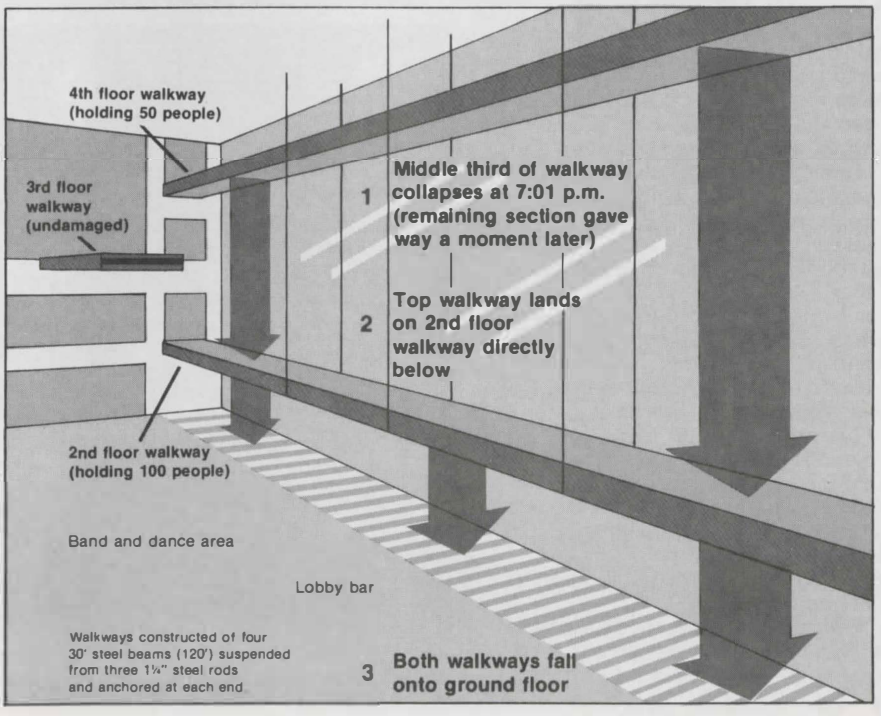
as they do in the books, an inside triage area is being established, and one hour after that, the whole system is starting to look like it's been there functioning that way for years. How did it happen?

First, we'll talk about the things we can explain:

The ASI Dispatch Center The Dispatch Center functioned amazingly well. In spite of some communications deficiencies, an antiquated dispatch console scheduled for replacement, and a recent takeover by a new Director of Dispatch Operations, the Center functioned beautifully. Only days before, Jack Morasch had written disaster protocols for the Dispatch Center and had in-service training for his dispatchers. But it also must be observed that the dispatch personnel responded resourcefully on their own. Finally, we believe it is reasonable to assume that a single dispatch center having continuous, complete, and exclusive control over every ambulance serving the City — emergency and nonemergency — greatly enhances the probability of superior coordination under periods of extreme stress.

Ambulance Disaster Response One of the reasons the system could place 14 paramedic ambulance units at the scene on a Friday night is that the system had 14 paramedic ambulance units that Friday night — it does every Friday night. If Kansas City utilized a different management model, it is likely that a two-tiered response would have resulted in some ambulances arriving at the scene with full paramedic capabilities, while others accustomed mostly to nonemergency work would have taken the place of additional paramedic units. We have always felt that a two-tiered system is undesirable, both financially and medically, for urban areas. And, if we had any doubts about this before, they are gone now.

The fact that all ambulance personnel serving Kansas City work for the same company and participate in the same in-service training program also contributed to the smooth response. As noted before, Doug Klote's disaster planning efforts and the associated in-service training programs have only recently been instituted at ASI, but the fact is that virtually every ambulance crew member serving Kansas City has been trained in the same procedures by the same instructors. Furthermore, these people work together every day. They do not work for competing private companies, and they do not work for one public agency trying to outdo another for the public relations limelight. At the scene, they knew each other by sight, understood each other's capabilities, and that probably contributed to the relative ease with which natural leadership patterns developed. More on that a



14 Hours

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also have been received, and it is clear to the dispatch center that a major emergency is in progress. All administrative people have been ordered in by the Dispatch Center, including MAST and ASI people, as well as personnel from MARCER, the regional EMS agency. The Hospital Association has been notified and is preparing to issue the standby for a Type 2 alert. Four ambulances are on the scene, with three more en route. A command post has been set up, an emergency physician is inside at the disaster scene, and ambulance units from neighboring communities are beginning to respond with offers of assistance.

At the scene, ambulances arrive to find hundreds of persons in the street, some with torn clothes, horrified expressions on their faces, many covered with blood. As ambulance personnel arrive, people surround them, begging for help for their friends, relatives, and sometimes themselves.

Inside the Hyatt, a walkway seven feet, two inches wide and approximately 120 feet long, suspended approximately 45 feet above the lobby floor has fallen onto a similar walkway suspended 30 feet beneath it, and both have fallen onto the floor. Apparently both walkways and the floor beneath were crowded with people attending a tea dance. Initial reports counted 110 dead and 188 injured. Our guess is that the system was faced with 80 to 100 critically hurt patients.

7:19 PM

Dispatch Center Director Jack Morasch, about five minutes away from the Dispatch Center, hears Unit 110 respond to a question from Car 1 (Patrick Smith) indicating that there may be as many as 100 injured parties. Jack Morasch radios Dispatcher Barbie Culli to call Johnson County EMS to get assistance from Medact, and also to request one unit each from Lee's Summit, Blue Springs, and North Kansas City. At this time, Unit 110 is trying to establish order outside the building, and is requesting that all ambulance units responding to the scene pick up patients at Pershing and Grand.

7:20 PM

Unit 110 orders two more ambulances, and Ambulances 141 and 120 are dispatched from separate locations. Unit 151 offers its services and is advised to stand by. At this point, all city ambulances except one were at the scene or enroute, leaving the city wide open on a Friday night. The Dispatch Center therefore asks for standby coverage of the rest of the City from Raytown to the east, Grandview to the south, Gladstone and Claycomo to the north, and Johnson County to the west. (Readers may note

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little later.

EMS/FIRE/EPF Cooperation Even though Kansas City's ambulance crews all work for a private ambulance company, Kansas City's ambulances are mostly based at fire stations throughout the City. Ambulance personnel and fire personnel in Kansas City generally have a good working relationship. When problems do come up they are usually small and easy to correct. Kansas City's fire and ambulance personnel work together daily, and share the same post facilities. This, we believe, contributed to the ease with which work was coordinated at the disaster site.

Similarly, the members of the Emergency Physician Foundation have worked closely with ambulance personnel over the past several months in the development of the new medical protocols, on-board equipment specifications, in-service training requirements, and in the conduct of routine medical audits. For the most part, ambulance personnel are beginning to feel that these emergency physicians know them and their capabilities, and the physicians in turn have learned to feel comfortable in providing medical leadership throughout the ambulance system. Again, this is another example of a situation in which people who deal with each other effectively on a routine basis are likely to interact more effectively during a crisis.

Regional Response From Mutual Aid Providers We believe

A Paramedic's Perspective

We were at our station Friday afternoon when I heard the first alarm go out for "some type of structural collapse at the Hyatt Regency Hotel." Battalion Chief 102, two pumpers and one truck company were sent. At this time I had no idea that my next 12 hours would be spent at the hotel undergoing the experience of a lifetime, and one I'd surely never forget.

About 45 seconds after Pumper 8 arrived, he came back on the radio, absolutely beside himself, screaming for ambulances, extra fire companies, and the deputy chief. At this time, my partner and I and Paramedic Unit 110, the Supervisor's car, were sent. Unit 105, being only four blocks away, was already en route.

Approaching the hotel, we could see over the traffic jam and fire trucks, hundreds of people running up and down the street, some with torn clothes, many with horrified expressions, many covered with blood.

Unit 110 arrived at the same time we did. The paramedic with Unit 105 was already treating patients in the street.

When I got out of the ambulance, there were people lying everywhere. Police officers were carrying people out of the front door of the hotel, bystanders were helping others out; and many people were just running into each other trying to get out of the hotel. It was absolute pandemonium.

I could see about 200 people outside. Half of them were lying in the grass and the parking lot driveway. Then a police captain ran up to me and said there were about as many more still inside the hotel.

I went back to my ambulance and put all lactated ringers, normal saline, and D_5W IV solutions in the street directly behind my unit, along with IV needles, tubing, spine boards, "C" collars and dressings. This way all needed equipment from our unit would be readily accessible rather than have someone have to rifle through all my cabinets. I had the other units do the same — a stockpile of equipment located in one place. When we completed this, I then went into the hotel. At about this time, Car 1 (MAST-Patrick Smith) arrived and ordered all available ambulances, activation of mutual aid, the Red Cross, and the Salvation Army.

When I walked into the hotel, people began pulling at me wanting me to help their wives, husbands, or friends. I had to decline because I had to find out just what we had in there. Approaching the skywalks, I could not believe my eyes. There were people chopped in half, just torsos lying about; people with limbs sheared off, people crushed flat, ones that were still trapped, screaming for help. There is no way I can explain the helplessness that overwhelmed me when I saw this. There must have been more than 100 people still in that hotel dead and in major trauma — and there I stood not knowing what to do next.

Immediately I began directing the bystanders to take the untrapped people out to the ambulances as quickly as possible — we needed to establish as much order as possible as quickly as possible, so we could start removing the trapped victims. The whole place looked like a bomb had gone off in the middle of all these people. Intestines, brains, bones, were everywhere. It was shocking.

I went to the street to get IV solutions and dressings and briefly told the street triage officer, Allen Askren, what we had inside. He was already overloaded with what he had. I also requested extra doctors and paramedics inside for stabilization of the trapped victims.

Going back inside, the Hurst tools and Quickie saws were already fired up and at work. There were about 75 to 100 firemen trying to free the victims. Those victims who were trapped with gross injuries and were probably going to die had to be overlooked to help those who had a chance. There just weren't enough medical personnel at this point to care for everyone.

You had to blank out their cries for help, their agony. You knew they weren't going to live, there was too much on top of them, most of their bodies couldn't be seen. It would take too long to move all of the tons of steel and concrete to save them — they were going to die, and I could not look at them because I would

by Jim Taylor

Paramedic Jim Taylor, megaphone in hand, directs rescue efforts of ambulance personnel from atop the fallen catwalks. (Photography was difficult due to extreme dust and fumes from small engine exhausts).

Photo by Ken Paton

that the history of the regional MARCER organization contributed substantially to the speed and smoothness of the mutual aid response from surrounding communities. In fact, the previous MARCER regional dispatch center, now taken over by ASI, provided primary and secondary emergency dispatch, as well as assistance in obtaining communications equipment for the entire region.

Perhaps just as important to this response was the recent activity carried out by the area Regional EMS Administrators Committee (REMSAC) which has resulted, in large part, from concern on the part of regional providers over the changes taking place in the Kansas City EMS System. Because of this concern, EMS administrators from throughout the area have recently taken an active role in helping to develop and formalize regional EMS dispatching protocols, including disaster planning efforts. Controversy has been an important con-

have gone to pieces myself. We had to help the ones who had a chance, or at least give them that chance.

A woman's arm was amputated to get her out. Because of other serious injuries she had to be transported at once. We had to take off a 26-year-old man's leg at the hip to get him out. (The section of catwalk trapping his leg couldn't be moved until 7:30 the next morning.)

It took about two to three hours to remove the victims trapped between the first and second catwalks — then there were those between the first catwalk and the floor. The catwalks had false bottoms, so it seemed very likely that there were people alive between the first catwalk and the floor. When all victims from the first rescue were removed, we made voice contact with a few people under the first catwalk. We couldn't see or touch them, but we surmised at least four to six people were alive under there.

At this point we turned the rescue over to the fire department, crane operators and iron workers. It was about ten or eleven p.m. During this time, ambulances were still transporting victims from the triage area and it gave me a chance to organize medical teams again — three to a team, a paramedic, two EMTs with L.R. IV sets, "C" collar and full spine board per team. When a victim was freed, the designated med team would advance, treat emergency problems and remove their patient to the triage area. I told them to hold off on treatment at the site unless absolutely necessary. When a victim was removed, another medical team was brought up into the staging area. This way we could keep the extrication site as clear as possible. We did not need the medical people getting in the way — everyone had a purpose.

During our rescue of the last trapped victims, we were talking with one male victim. He was telling us where to cut through next, and so on. Then he became silent. When we finally reached him, he was dead.

Going down into the holes we had cut in the concrete walkways was a horrible experience. Dead victims had to be dismembered to get to the live ones — and by this time, about 2 a.m., the smell was overwhelming. The possibility of another live one drove us on. An entire book could be written about that night.

It went well, very well. I feel good about it.

I can't say enough for all those who went above and beyond the call that night.

You experience this and you learn, and you learn well.

I feel sad about those who had to die but I think more now about those who lived, who got a second chance.

When we used to make shift changes, in leaving, someone would say, "See ya at the big one" — well, a lot of us think a little before we say that, now. □

About the Author: *Jim Taylor is a senior paramedic in the Kansas City EMS System. He was working Unit 901 the night of the disaster. He prefers to work as a field paramedic, rather than in a management capacity, but has been an active participant in the recent development of the Kansas City System, assisting with the development of system status management plans, on-board equipment standards, and vehicle specifications. Taylor's clinical capabilities, control, and leadership qualities combined the night of the Hyatt disaster to thrust him into a role as coordinator of rescue operations. Working side-by-side with Dr. Joe Waeckerle at the site of rescue operations, Taylor could be seen throughout the night, often standing atop the fallen catwalks, megaphone in hand, directing and coordinating the ambulance personnel operations. We knew things were bad when Taylor, famous for his neatness and attention to detail, was seen with his shirt partially unzipped — a severity indicator never before witnessed. Taylor's firm and steady leadership throughout the night brought confidence, inspiration, and pride to us all.*

14 Hours

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that 13 Kansas City ambulances are now at the scene or enroute, but not all 13 have been dispatched. At the moment, we are unable to reconstruct the sequence to account for this discrepancy.)

7:23 PM

Unit 110 is calling for the Dispatch Center, asking the Center to contact the Red Cross to ask for assistance. 110 also requests three more physicians at the scene, plus additional assistance from the EPF. The Dispatch Center gets one more doctor from Truman Medical Center, and from Baptist Hospital, Dr. Joe Waeckerle. Unit 140, is clearing Truman Medical Center after dropping off a patient, and advises that they will pick up the doctor at Truman and deliver him to the scene.

7:27-7:30 PM

Approximately 20 minutes after arrival on the scene, 110 experiences problems with traffic and advises that they are blocked in by fire trucks. The Dispatch Center calls the Fire Department for assistance. Traffic control is becoming a serious problem. Ambulances are being routed past the outside triage area in a single lane running south to north, but occasionally congestion requires an alternate flow. (Unit 310 has started to the scene of the disaster, but is diverted to handle a Code 1 police request while en route to the disaster scene.)

7:34 PM

Supervisor Allen Askren on Unit 110, acting as Triage Officer, is requesting region-wide response of all providers to the scene to assist with the operation.

7:36 PM

Unit 101 departs from the scene enroute to the hospital, apparently with the first patient transport.

RECAP at the scene

Initially, chaos. But soon, an order begins to develop. Paramedic Jim Taylor begins to coordinate rescue efforts inside the lobby. Soon, Dr. Joe Waeckerle assumes control of rescue activities in the lobby area, with Paramedic Jim Taylor, often standing on top of the fallen walkways with a megaphone, coordinating the execution of Waeckerle's directions. Fire personnel on the inside of the building coordinate their efforts smoothly and effectively with the work of the medical personnel. As the night wears on, construction personnel, fire personnel, and ambulance personnel will all work together as an effective team under the general leadership of Dr. Waeckerle. Many of the decisions to be made, both medical and nonmedical, would be

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tributor to this intensified regional activity, but the fact is these administrators know each other, deal with each other at least monthly, and have already participated in trying to iron out regional dispatch protocols.

These authors were a little bit surprised that mutual aid providers were so willing to assist by providing emergency coverage throughout the City, as opposed to the disaster site itself. We would not have been surprised if some mutual aid providers would have insisted upon supplying mutual aid directly to the scene of the disaster, rather than by providing the badly needed coverage elsewhere in the City. But, upon investigation, we discovered that every mutual aid provider cooperated one hundred percent, and did not question the ASI dispatchers' orders concerning city coverage. This indicates to us an unusual awareness of the realities of disaster response, as well as a mature and responsible attitude during a time of disaster.

All of us in the Kansas City EMS System are deeply grateful to our neighboring EMS providers for their assistance both at the scene and throughout our community that night.

The Extrication Effort Under the direction of Deputy Chief Arnett Williams, Fire Department personnel at the scene of the Hyatt disaster performed what was perhaps one of the most difficult extrication jobs of all time. And they did so in complete harmony with medical personnel working the same disaster scene. Furthermore, they also coordinated the work of construction workers, crane operators, jackhammer operators, and others.

To someone who wasn't there, it may be difficult to understand why it was so hard to assess the extent of the rescue problem. You could stand there looking at the catwalks stacked one on top of the other with parts of people sticking out every couple of feet all the way around, and it just wouldn't register. Medium and heavy extrication equipment was brought into play, and we all expected it would work. It just seemed impossible that we couldn't somehow get those people out from under there, and soon. But, gradually, it became clearer and clearer that this was going to be an all night affair, that heavy cranes were going to be necessary, and that we were going to have to deal with the problem one step at a time. It meant that careful thought would have to replace textbook action, It meant that, unless great care was taken, additional injuries could easily be inflicted upon rescuers and victims alike during extrication. And it meant that someone had to decide which sections to begin with, and which to leave to be dealt with hours later. Soon, everyone settled in for a very long night's work.

On-Scene Care and Transport During the first 20 minutes or so, things were pretty chaotic. Hotel workers and bystanders were moving victims everywhere. One small group of victims had even crawled off to huddle together in a hallway off the main lobby. The walking injured seemed to be everywhere. Ambulance crews drove up, left their ambulances to go inside, and then when it came time to transport, the

Rescuers working at South end of fallen catwalks. The tilted section at left had to be secured by crane before other sections could be lifted by additional cranes, due to likelihood that it would slide to floor when sections on floor bracing it were removed. Victims are trapped between the two layers and also between the floor and bottom catwalk.

Photo by Ken Paton

drivers had to be found.

But in a very short time, the outside triage area was set up and functioning well, and an inside triage area was being set up. Eventually, the outside triage area finished its work, and the inside triage area received patients in assembly line fashion.

The whole operation smoothed out amazingly fast. Soon ambulances were rolling in, lining up single-file in a one-way path, receiving patients and moving on. Drivers stayed with their ambulances, and after initial stabilization by physicians and medic teams in the triage area, ambulance personnel loaded their patients in the next available ambulance, leaving one or more medics to accompany the patients in the ambulance, with the rest returning to the triage area or to the disaster scene itself.

Returning medical personnel were organized by Doug Klote into three-person teams, and then were sent into the disaster area as requested by Paramedic Jim Taylor.

This whole process eventually got so smooth that, sometime during the night, we heard a physician comment that he hated to quit now that the team was getting so good.

The one area of transport where coordination was never established was Life Flight helicopter operations. It appears that the Life Flight crew failed to check in with the triage officer or even the communications officer. As nearly as can be determined at this writing, Life Flight crew members selected patients of their choice and transported them to their (the crew's) selected hospital. Imagine what would happen if all crews on the scene had operated in such a fashion. Why this rather glaring breakdown in on-site coordination?

One possible explanation is that Life Flight is not well integrated into the routine operations of the ambulance system anyway. In recent months there has been some effort, and a small controversy, over the operation of Life Flight in the City. In fact, at a recent meeting of the Regional EMS Administrators Committee there was even some argument concerning the proper integration of Life Flight operations into the new disaster plan. MAST and ASI officials felt that all requests for Life Flight into the city should come through the dispatch facility — not go directly from police, fire, or whoever, to the Life Flight dispatcher. But a firm protocol was not established.

The scope of this cooperation gap was further demonstrated the night of the disaster when the City Health Director officially released Life Flight. The crew remained, saying that only the Fire Department had the authority to release them. (As it turned out, the Fire Department had released Life Flight before Dr. Biery released them, but the crew for some reason had remained on the scene.)

Clearly, during a disaster event, *total* cooperation of all on-scene providers is in order. In this case, we are convinced that the absence of routine coordination with ambulance operations in the City contributed substantially to Life Flight's coordination failure at the Hyatt. We are reminded of a lesson from police street survival training: in a crisis confrontation, people revert to their previous training. Proof of this fact was the spent brass in the pants pocket of a California law enforcement officer killed in an extended gun battle...he had taken time to save his brass when reloading, just as he had always done in practice.

Life Flight is a valuable resource and should be integrated fully into our ambulance operations — routinely and in disaster situations.

Leadership and Cooperation A lot of disaster planning, including some of our own, has dwelled heavily on the issue of command structure at the scene. Authority hierarchies seem important when planning for a disaster. However, as a result of our experience at the Hyatt, we are forced to rethink that orientation. Let's look again at what happened:

Keep in mind that this disaster stressed the entire emergency system in just about every way, and nearly to the limit, and for a duration of about 14 hours. Also keep in mind that, in spite of what we are about to say, or maybe because of it, the overall response was superb.

In retrospect, we can identify eleven functional areas which required coordination and leadership of some type:

1) Dispatch operations.
2) Medical operations at the disaster site itself (inside the lobby area).
3) Medical operations at the two triage areas.
4) Extrication efforts, including maintenance of safety at the rescue site.
5) Coordination of ambulance move-

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difficult, but persons in charge of the various agency personnel on the inside would work together professionally, confer with each other in decision-making, make decisions carefully yet rapidly, and then implement those decisions methodically.

On the outside, Allen Askren directed EMT Gary Frank to assume a kind of coordination of the outside triage area. Gary Frank stripped every ambulance in sight to create a sort of "field supply stockpile." On the inside, in another part of the hotel, Dr. Bill Robinson, Chairman of the EPF, created an inside triage area, with both triage areas feeding patients, almost in textbook fashion, to the continuous lineup of ambulances now arriving and departing smoothly under the direction of Allen Askren and Communications Officer Steve Thomas. Ron Norman, of the Kansas City Area Hospital Association took up a position beside Steve Thomas' command vehicle, and established contact with all area hospitals on the HEAR system.

ASI's Doug Klote would deal with a number of activities throughout the night, but as the whole operation gradually evolved into a smoothly working routine, Klote would find himself organizing medical teams of EMTs and paramedics to be ready for a return to the lobby area.

7:40 to about 8:00 PM

By around 8 o'clock, the Dispatch Center was beginning to restore some coverage to the rest of the City. ASI Unit 121, a car normally based in Independence, Missouri, was moved in closer to the disaster scene to cover the City, and also to be more available to the disaster scene if needed. Lee's Summit ambulance, Unit 162, apparently did not have direct communications with the Dispatch Center, but through their own dispatcher were moved to Kansas City Fire Station 29 to cover the midsouth part of the City. Meanwhile, a unit from the Liberty Fire Department was moving to Fire Station 40 to cover the north part of Kansas City.

The City of Raytown was bringing in additional off-duty personnel, and Grandview was standing by to cover the extreme southern part of Kansas City. The Gladstone unit, which normally keeps one paramedic with the ambulance and uses a police officer to meet them at the scene to function as driver, called in an additional paramedic so that they could respond anywhere in the north part of Kansas City. With Gladstone now covering the north part of Kansas City, the Liberty unit was then pulled from Station 40 and brought into the disaster scene for additional assistance.

This early in the disaster, Allen Askren cannot release any ambulances from the

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ments into and out of the disaster scene area.

6) Coordination of and communications with hospital emergency departments throughout the area.

7) Acquisition and disbursement of field supplies and related equipment.

8) Coordination of medical personnel between tasks (i.e., after loading a patient on an ambulance, or after returning to the scene from a hospital, ambulance personnel were formed into three-person teams, equipped, and then made available to persons directing medical operations in the lobby upon request)

9) Traffic control, crowd control, and site security.

10) Coordination of body removal.

11) Communications at disaster site.

The Fire Department's work in managing and supervising the *extrication work*, and in maintaining *site safety*, was planned. The fire service in Kansas City provides excellent first-responder assistance to the paramedic program on a daily basis, and the Fire Department's extrication capabilities are so good that our ambulances carry almost no extrication equipment on board. Under the direction of Arnett Williams, the Fire Department did its job extremely

An EMT's Perspective

I had agreed to work an extra eight hours that night on Ambulance Unit 105 for a friend. The shift started out as usual, checking the car for supplies, filling the gas tank, and being assigned to stand by in a parking lot near downtown.

At approximately 7:10 p.m. we heard the dispatcher call the dispatch supervisor to return to the dispatch center immediately. Then we heard them advise the supervisor that there was a possible disaster. At that point we were dispatched to the Hyatt Regency — Code One (emergency)... on a roof collapse... possibly with mass casualties. This was hard for us to imagine as the building was new — a showcase hotel. While we were en route I heard a couple of other ambulances being dispatched to the same location. This was out of the ordinary, because the first ambulance on the scene is supposed to advise as to the need for additional units.

Upon our arrival we observed hundreds of persons in the streets, as well as two or three fire vehicles and a couple of police cars. The firemen and policemen were frantically motioning us into the building. My partner, Gary Trinidad, proceeded inside. I stayed with the ambulance and notified the other ambulances en route where I needed them. As I was talking on the radio I had approximately 20 persons surrounding my ambulance saying that they were hurt, or wanting me to come with them to look at someone who was hurt.

The first patient I saw was a woman who informed me that she was a "free bleeder" and pointed to a bloody handkerchief around her arm. The next was an older man who came up and stated he had a headache. This gentlemen had a bloody face and was missing half an ear. At the same time I received reports from citizens, some who said they were nurses, about a pregnant lady over here, a man with half his head missing over there, a lady with chest pains, and several people with bones showing through the skin.

At this point Ambulance Unit 901 arrived. I asked them to go over to where I had reports of the most serious injuries. Another ambulance, Unit 110, pulled in about 50 yards behind me. This ambulance contained the field supervisor, Allen Askren, who became the official triage officer and his partner, Steve Thomas, who became the communications officer. After their arrival I instructed patients to gather in the street between our ambulances. I then made a quick set of rounds, going wherever I was told there were patients. I observed numerous fractures, lacerations, and people with blank stares on their faces. I couldn't understand the stares at the time, for I hadn't yet seen the devastation inside. Eight hours later, I would understand.

The next few hours flew by. Splint this leg! Immobilize that arm! Dress this wound! This patient needs a backboard and cervical collar! This patient needs an IV! Get more supplies! Which hospital shall we go to? How bad are your patients? These sentences were resounded many times in the next hours. EMTs and paramedics working with doctors and nurses; civilian volunteers helping as much as possible. Ambulance services from many jurisdictions supplied equipment without concern over when, if ever, their equipment would be returned. Chaos became organized in a very short period.

At long last we no longer had patients waiting to be transported to hospitals. It now became a waiting game. We knew we had more patients, but we didn't know how many. Reports came to us that muffled voices were being heard from under the debris. Activity at the outside triage area slowed down.

Activity was continuing on the inside. Jackhammers pounded and power saws gnawed into concrete and steel. It was at this point that I could smell an odor all too familiar...an odor that can only be described as pungent and always at death's side.

I walked toward the hotel to see what monster had inflicted so much pain and grief on such an innocent looking group of people. I peered through what was once a large window...now only an opening bordered with wedges of glass. I

Photo by Ken Paton

The outside triage area was coordinated by Gary Frank, who stripped every ambulance in sight to create a sort of "field supply stockpile." This photo was taken 30-40 minutes after the start of the disaster.

by Gary S. Frank

well, cooperation was almost flawless, and that didn't surprise any of us in the EMS system.

Coordination with the *hospital emergency departments* throughout the area had been the subject of disaster planning and disaster exercises for years. At the hospitals things apparently went very well, after some initial difficulty in bringing up all the hospitals on the HEAR system. However, our review of the events indicates that the periodic polling of emergency departments, as provided for in most traditional disaster plans, did not always provide the triage officer and transporting crews with sufficiently up-to-date information to properly direct patient flow. There was simply

entered the hotel. "God damn," I thought as I saw a head and an arm, neither connected with a torso. After a moment I reconsidered... "No, not God damn... My God... How? Why? This isn't supposed to happen... not in my home town... not in Kansas City... not to Kansas Citians..." I then prayed for a moment... for the injured, for the loved ones, but most importantly at the time for the ones we had yet to see... the living ones trapped with no relief in sight.

Inside the hotel I found my partner who seemed understandably wound up. My partner and I joined forces on the north end of the collapsed walkway. That segment was being lifted and we checked for any signs of life. We pulled lifeless torsos out... some intact, some not. In the process of removing those awful sights, I noticed I was standing in a pool of blood two inches deep. At this point I asked myself, "what am I doing here?" I found no answer. I looked up from the sights below and saw a priest giving last rites. He also was standing in that pool. I looked behind me and saw Kansas City's Mayor Richard Berkley, not more than three feet from me. I looked to one side and then the other. What did I see? People working steadily and persistently — determined people hoping the next body pulled out might be talking or at least moving in the slightest way.

The jackhammers quit hammering and saws quit gnawing. A hush came upon us and all of a sudden... cheers and applause. We got one out. "We" ... it's an easy word to use in this case. It was a team effort... as was everything that happened that dreadful evening. The cheers and applause occurred two times later in the early morning hours, which made the gruesome chores of the evening almost bearable.

Darkness turned to only dim. Rain came and went throughout the night. The rain seemed somewhat symbolic. It fit into the gruesome atmosphere that we had been exposed to for the previous ten hours.

At last, the final segment of the walkway was being removed... the center. The cranes and fork lifts had the segment lifted about two feet off the floor. Everyone squatted down to look and listen for the smallest movement or the tiniest whimper. No such luck. Firemen looked for their missing chief, known to have been present at the dance the previous evening. As the segment was lifted higher and secured, the body count rose. Bodies were being removed rapidly. The bodies were frozen in the most awkward positions... the positions they were in some 12 hours earlier when their entombment was forced upon them.

The final body was taken to the make-shift morgue. It was over... no need to hurry, no need to run, only recollect. Could I have done this? What if we had done that? Then after all the "could I's" and "what if's" died down, there was the one question that will remain... why?

Now everyone is looking for blame and fault. I guess that's to be expected. However, I can only look back at all the volunteers, all the off-duty police, fire fighters, and paramedics, the doctors, nurses, the Red Cross, and the Salvation Army ... all those people. This City is full of people with an overwhelming concern for each other. We did well. □

About the Author: *Gary S. Frank is an EMT with 15 months field experience in Kansas City, Missouri. He is currently working toward paramedic certification, as well as a B.S. in Administration. He was on one of the first two cars to arrive at the Hyatt. He performed initial triage outside the building and gradually assumed responsibility for liaison between the triage officer (outside area), the communications officer, and transport units. He provided liaison with the Police Department, prepared patients for transport, insured that the triage officer's directives were carried out as patients were prioritized for transport, and coordinated assignments of hospital destination between communications officer and drivers. After the outside triage area was cleared, he assisted inside with excavations. Gary arrived at the Hyatt on Unit 105 at 7:12 p.m., about four minutes after receipt of the first call. He departed the scene at approximately 8:00 a.m., after the last body was removed.*

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scene, and in fact is ordering taxicabs into the area to transport the walking injured. All Code 3 (nonemergency) calls are suspended for the night, including calls requested by the VA Hospital requesting transfers to Topeka and Leavenworth. (In the Public Utility Model, all nonemergency transfer work is temporarily suspended during a time of extreme system overload, and the health care community is expected to understand and support this occasional inconvenience, as did the VA Hospital during the Hyatt disaster.)

8:00 PM to about 7:00 AM

Sometime shortly after 8 p.m., all 14 ASI units, and two additional ASI units brought into service, are working the disaster, along with several ambulance units from neighboring communities. By 8 p.m. most of Kansas City is being covered by ambulance units furnished by neighboring EMS services which, in some cases, is a problem since not all of these ambulances have direct radio contact with the Kansas City Dispatch Center, making it difficult to provide directions to drivers unfamiliar with Kansas City streets. Even so, neighboring providers handled 12 to 15 emergency calls throughout the City while the disaster was in progress. Later that night, as one of these neighboring units would clear a Kansas City hospital, having dropped off its patient, the Dispatch Center would start them en route to the Hyatt. Then, when an ASI car left the Hyatt with patients and cleared the hospital, the dispatch Center would pull the ASI car out and use it for city coverage, since the ASI drivers are obviously more familiar with the City and could be better used in that capacity. As the night progressed, ASI gradually restored its own city coverage, and providers offering mutual aid were increasingly utilized at the scene of the disaster, though ASI units worked throughout the night.

As nearly as we can determine at this writing, assistance was supplied by Blue Springs EMS, Lee's Summit Fire Department, John Knox Village, Liberty Fire Department, Raytown Ambulance, Medact, Merriam and Mission, Kansas, Huckaby and Sons Ambulance out of Kansas City, Kansas, North Kansas City Fire Department, Children's Mercy Hospital, Osteopathic Hospital, Transfer Service, Inc. of Odessa, Missouri, KARE from Kansas City, Kansas, and the Shawnee Fire Dept. In addition, essential standby coverage was provided by Gladstone, Gold Cross Ambulance (from Independence), Grandview, Claycomo, and Raytown. In all, it appears that approximately 16 ASI ambulances plus 15 ambulances from mutual aid providers were involved. □

too much happening too fast to rely upon the traditional polling method. As a result, the Dispatch Center became actively involved in helping to coordinate the assignment of patients to hospitals. In retrospect, it seems that hospital communications would be more effective if carried out from the Dispatch Center — rather than from the disaster site, and the person carrying out this important function probably should have medical, rather than administrative, skills — paramedic, emergency nurse, or equivalent credentials.

However, even though we did learn something about how to improve the process of assigning patients to hospitals, the fact is that process worked very well at the Hyatt disaster, due more to the cooperation which developed than to any preplanned systems or procedures. The Hospital Association's Ron Norman, Communications Officer Steve Thomas, Triage Officer Allen Askren, Gary Frank, Dispatch Center personnel, and hospital emergency department personnel somehow made it all work. The success was in the people — not in the plan.

Acquisition and disbursement of *field supplies* and *equipment* was one area that could be improved upon substantially. There really was no plan for establishing a field supply inventory and distribution system. As a result, each triage area created its own supply inventory in any way it could. Throughout the night, people working in various areas would require a piece of equipment or some supply item, and there was no organized way to get it. For Example, Jim Taylor, having benefit of megaphone, might ask for an item and either get 50 of them or none, depending upon who happened to hear it, what they were doing at the time, and if they knew where they could find the item.

Field supply inventory and distribution turned out to be one area of need which really required prior planning to be handled most effectively. A disaster supply inventory should be developed and maintained, and some means of transporting that inventory to the scene should be available. Furthermore, a field supply officer should be identified, and a distribution mechanism (i.e., runners) set up immediately, along with means of communicating between the extrication site, triage areas, ambulance loading site, etc. and the field supply depot. Even though none of this had been done, people somehow managed to obtain what was needed through cooperation.

Coordination of medical personnel between tasks was a function that, frankly, we had never thought about. But it proved to be necessary, and ASI's training officer, Doug Klote, saw the need and filled it.

Whether handled formally or informally, well or not so well, these are the 11 areas of functional responsibility that had to be dealt with in order to effect an adequate response at the Hyatt disaster. For the most part, and with only a few exceptions, each of these areas of need was handled extremely well. What is hard to explain is how each of these areas was handled, and how an on-scene organization was rapidly developed to make everything work. Let us discuss each of those above-listed 11 areas of performance.

The 11 Areas of Performance

We have already discussed how the *Dispatch Center* worked, and how mutual aid providers cooperated fully with Dispatch Center directives. The success of Dispatch Center operations during the disaster was probably enhanced considerably by the fact that all of Kansas City's ambulances are *always* under the control of one Dispatch Center. Kansas City EMS routinely maintains about a four-minute average emergency response time, furnishes ALS capability on every run, handles 95 percent of its emergency calls with a response time under eight minutes, and provides nearly equal response time performance throughout all of the six councilmanic districts of the City. And it does this at a total cost, emergency and nonemergency service combined, of less than $4 million per year, including fees collected and a per capita local tax subsidy well under $1.50 per year.

Of course, none of this "routine performance" would be possible without complete coordination of all production capacity from a single dispatch facility. So in some ways it is not surprising that in the face of a huge disaster overload, that same dispatch facility is also capable of diverting the City's entire response capacity to a single location, while relying upon mutual aid providers to

handle the emergency "business as usual." In other words, a control center accustomed to managing all of the City's ambulance resources every day is better equipped to manage those same resources, plus mutual aid when disaster strikes.

Medical operations at the rescue site somehow came under the control of Paramedic Jim Taylor and Dr. Joe Waeckerle. How? It needed to be done and they did it. And everyone else saw that it was necessary, saw that Waeckerle and Taylor could do it, and gave them the support they needed to operate. This wasn't part of any plan, and neither Jim Taylor nor Joe Waeckerle occupy any special position which would make them more likely than anyone else for the task. Nonetheless, there was never any question about who was in control of medical operations at the rescue site. In fact, persons directing fire department operations in the lobby area conferred with both Dr. Waeckerle and Jim Taylor throughout the night, and we believe it is not inaccurate to say that most strategic decisions made at the rescue site were made almost by a consensus process involving Waeckerle, Taylor, fire officials, and occasionally the construction people.

As for the operation of the *two triage areas*, the outside triage area was set up and operated basically in accordance with the disaster plan recently developed by ASI's Doug Klote. The field supervisor acted as triage officer, and his partner acted as communications officer. Ron Norman from the Area Hospital Association arrived and established hospital communications. The important role played by Gary Frank at the outside triage area seemed to evolve out of necessity and capability. Things needed to be done and Gary Frank could do it, so he did. The job description was written after the job was done.

But the inside triage area, developed primarily under the direction of Dr. Bill Robinson, was not part of any disaster planning. It needed to be done, Dr. Robinson knew how to do it, so he did it. Execute the plan and then go write it.

As the night progressed, it became automatic for ambulance personnel to complete a task and then return to a sort of "staging area" where Doug Klote was re-forming and re-equipping three-person teams which were then sent into the extrication area at Jim Taylor's direction. Again, this operation wasn't part of any plan — it just developed. And it worked well.

Traffic control, crowd control, and site security was handled, as expected, by police. There was some initial confusion and traffic congestion which was quickly brought under control, and probably there will be some opportunity to prevent or reduce these problems in the future by additional planning and training. The one-way traffic corridor could have been established a little earlier, and some congestion could possibly have been avoided. But this confusion was brought under control with surprising speed, and a very orderly process was developed and maintained throughout the night. The secret was not so much in any plan as it was in the ability of a few individuals to see the problem, map out a solution, and implement it with the cooperation of others.

Coordination of body removal was handled so well that we really don't remember any significant problems in that area. In Kansas City, most body transfer work is done by a private company, Morticians Transfer Service, owned by Shannon Holcomb. Holcomb and his crews arrived on the scene, along with at least one official from the County Coroner's Office, and a temporary on-site morgue was set up. As bodies were removed from the extrication site, they were taken to the makeshift morgue where they were processed and eventually transported. We spoke with Holcomb sometime in the early morning hours and observed the body removal operation. There seemed to be no major problems, except the problem of identifying the bodies of female victims. Purses were scattered and most of the women carried no other identification.

Although there had been much controversy in recent months concerning the body transport business in Kansas City, including a lawsuit over the matter, these authors have been supportive of having most of this work performed by equipment and personnel other than our advanced life support ambulance units. ASI owners have occasionally, but not forcefully, disagreed with us on this point, and for reasons we don't fully understand, Mortician's Transfer has even sued Stout

personally. Even so, we continue to support the separation of the body transfer business from the ALS ambulance business, and we were pleased that the body transfer work that night was handled by a separate firm, leaving ASI and the mutual aid providers to concentrate entirely upon the living.

The final area of organizational consideration was the problem of *communications at the disaster site* itself. The best method of communications at the disaster site was Jim Taylor's megaphone. The second best method was to run and tell somebody something. In other words, there was no good way for Jim Taylor and Joe Waeckerle to communicate with Bill Robinson in the inside triage area, or for Bill Robinson to communicate with Allen Askren in the outside triage area, or for communications officer Steve Thomas to communicate with Bill Robinson, etc., etc., etc. And, the problem was compounded by the fact that there was no field supply officer to talk to, even if you could have communicated. On-site communications were dismal.

As of the writing, plans are underway to correct this problem in the future. We know that a powerful and effective public address system should be established almost immediately at the disaster site. In this case, it should probably have been controlled by the person occupying Jim Taylor's position. A communications officer should be established at each of the areas (i.e., extrication site, triage areas, ambulance loading site, traffic control and security site, and field supply depot). Each of these communications officers should maintain contact with the others via handy-talkie on a controlled channel designated exclusively for the purpose of on-site inter-area communications. We made do with what we had, and we did very well. But we can do better.

Conclusion

We wish this was the conclusion, but it isn't. The psychological impact upon this entire city is enormous—greater than we could ever have imagined. Somehow there is something different about this kind of disaster. Danger goes with riding in cars, flying in airplanes, participating in sports, fighting a war... but a tea dance? Inside a plush new hotel? We are reminded of our frailty, our mortality, the uncertainty of our existence. We have seen an incredible thing. We are all changed and we don't know to what extent.

On re-reading this report, it seems accurate enough, considering that at this writing it's been only two weeks since the disaster took place. Kansas City Health Director, Dr. Richard Biery, has appointed a task force of well-qualified people to review the EMS system's performance and to recommend improvements for the future. No doubt, we will learn a great deal more from that inquiry — things that this early report may only hint at, or even overlook entirely.

But, there is something else wrong with this report. It's accurate enough, but its focus still seems wrong. It is true that the progress we have made in Kansas City EMS over the recent months probably con-

tributed to our performance at the Hyatt. And, it's true that recent disaster planning efforts probably also helped. But it wasn't the Public Utility Model, our administrative efforts, or any disaster procedure that delivered the goods at the Hyatt disaster. It was just people.

And this is the point we would most like to make: a smoothly functioning, high-performance organization was developed on the spot. Leaders emerged, and were recognized and allowed to lead because they were capable, willing, and because it was necessary. Many of the 11 functional areas discussed toward the end of this article could well be viewed as "departments" of an ongoing organization. People, mostly all by themselves, formed an organization, almost departmentalized, evolved managers, assistant managers, and a work force with the intelligence and maturity to take direction from those who could and would lead. These "department heads" worked together almost as though the organization had evolved formally and over a period of years. That's what really happened.

Now, we're all feeling the aftershock. Our symptoms are diverse, but it appears we all have them. At the time, not everyone withstood the strain, the test, with equal grace and dignity. In a very few isolated instances the strain overwhelmed, tempers flared, and in a few unfortunate instances, individuals attempted to exercise leadership by virtue of their perceived authority. That wasn't necessary.

We supposed we could write a disaster plan and include in it a mandate that everyone will hold up, no one shall lose his or her temper, everyone shall respect the others, and no one shall assume the role of an ass. We could write it that way, but it won't work that way. We'll do better if we recognize that, with hundreds of people injured and hundreds of others helping them, not everyone will stand the stress equally well. Not everyone will be star.

Under extreme stress, there is no loss of honor in failing to perform perfectly. Some individuals are bound to lose control. Some will attempt to mask their feelings of helplessness by becoming overbearing, perhaps dictatorial, seemingly in control. It's bound to happen. But success occurs when those who can remain in control of themselves are able to work around those who can't, without confrontation, without animosity, and with the same compassion and understanding that we exhibit for the other victims of the event.

We did very, very well. But many of us are now confused by the powerful ripples of aftershock emotion. Guilt, elation, fear, anger, disgust, helplessness...all these feelings, for some of us, come and go, sometimes simultaneously, and we try to hide them and go on about our business. The disaster isn't over. We must continue to help the victims who are ourselves.

Epilogue

What does this mean about our EMS system? For one thing, it means Kansas City EMS may be getting pretty good. Good enough to stop improving? Hardly.

We are reminded of an analogy we often use in comparing the evaluation of an EMS system with the evaluation of a marriage. We may be willing to risk our lives for our mate in a dramatic gesture of salvation. But this does not prove our love, for we are almost as likely to risk ourselves to save a stranger. The question isn't whether I would risk my life to save my wife; the question is whether, on a Sunday morning, sitting in my easy chair drinking coffee and nursing a slight hangover, do I drink my coffee more slowly in hopes that she will get up and bring me the next cup, or do I toss down the last gulp so I can refill our cups myself? It's the little stuff, the everyday stuff, that tests our love.

In EMS, we must evaluate ourselves on how we perform when the adrenalin *isn't* flowing. When the drama *isn't* present. Do we drop our patients off and return to our units quickly to be ready for the next call? When dispatched, do we go en route in 30 seconds, or do we take longer? Do we read our trade journals faithfully so that we know what's going on in our industry? Our performance must be judged in at least a hundred not so dramatic ways.

So, back to work. Let's see...we left off trying to organize a new paramedic assist program for fire department personnel...and we've got to in-service the dispatchers on the new dispatch data system and the new dispatch computer...and we've got to redo our vehicle bid specs... □