

# Baltimore's Unrest: Perspectives From Public Health and Emergency Physician Leaders

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## ABSTRACT

The tragic April 19, 2015, death of an African American man injured while in police custody spurred several days of protest and civil unrest in Baltimore City. This article outlines the opportunity and role for a local health department during civil unrest, from the perspective of 2 emergency physicians who also led the Baltimore City Health Department through these recent events. Between April 27 and May 8, 2015, the Health Department was a lead agency in the unrest response and recovery activities. Similar to an emergency medical situation, a “public health code” is proposed as a model for centralizing, reacting to, and debriefing after situations of civil unrest. (*Disaster Med Public Health Preparedness*. 2016;10:293-295)

**Key Words:** local government, delivery of health care, public health, emergency medicine, multi-agency coordination

On April 27, 2015, Baltimore City was thrust into the national spotlight. After the untimely death of 25-year-old Freddie Gray, an African American man injured while in police custody, many united to protest social injustice, police brutality, and the broad inequities that exist in a city where the life expectancy differs by 20 years on the basis of where people live.<sup>1</sup> Most protests were peaceful demonstrations challenging the structural racism and lingering inequalities across the United States that disproportionately affect young African American men.

Unfortunately, some of the Baltimore demonstrations turned violent. On the afternoon of Freddie Gray's funeral, there were reports of a planned city “purge”—a deliberate attempt to disrupt the city's infrastructure through destruction and fire. Within hours, televised news stories showed looted stores and pharmacies, burning police cars, and angry youth pouring into the street. Threats were ongoing against city property and police, and uncertainty remained as to what would happen next. Baltimore Mayor Stephanie Rawlings-Blake mobilized city agencies in the citywide Emergency Operations Center, a centralized location for agency leaders and staff to coordinate an emergency response strategy. Maryland Governor Larry Hogan declared a state of emergency and called in the National Guard, which remained in effect from April 27 to May 6, 2015.

## NARRATIVE

As the 2 physicians at the helm of the Baltimore City Health Department, we had a unique perspective on the role of the local health department during civil unrest. Police, fire, and emergency management all

had defined roles. In an emergency response, the role of the health department was less obvious. At the onset of the unrest, we were called to be a lead agency at the forefront of the efforts.

At the beginning, our role was to assist police and emergency medical services (EMS) to ensure that hospitals could safely care for their patients. We coordinated safe routes with hospital emergency planners and also ensured that our operations in the health department continued, including field health transport for patients going to and from dialysis and chemotherapy. One of our health clinics, Druid Health Center, is located at North and Pennsylvania—directly across the street from the CVS that burned down. We had to arrange for the safe transport of patients and staff out of the building and coordinate reopening of this clinic and other clinical operations in the midst of the uncertainties of the next few days. Many of our clinic staff live in the neighborhoods affected by the riots and are extremely dedicated to the population we serve. We had to balance this dedication and desire to remain open with a potential safety threat to our staff.

The role of the local health department thus did not end with immediate threats to safety. Thirteen pharmacies were closed due to fire, destruction, and looting. We heard from an elderly woman who had run out of warfarin to treat her pulmonary embolism. Another woman with diabetes had no more insulin and was sleepy with blurred vision. Others called because they depended on their local pharmacies for more than medications: they were also out of their adult diapers, Ensure nutritional shakes (Abbott

Laboratories, Abbott Park, IL), and food. It was evident that the city health department would need to provide coordinated, ongoing support to ensure the availability of essential health services, medications, and supplies for Baltimore City residents.

### DISCUSSION

As public health leaders who are both board-certified emergency physicians, we immediately went into action. It quickly became apparent that the skills we use every day in the emergency department were critical. This was what we called a “code” in the hospital: an emergency scenario with an acute situation requiring an immediate and coordinated response. Just like an emergency physician running a code, preparation, centralized leadership, closed-loop communication, flexibility, and debriefing were critical aspects of the Baltimore City Health Department’s response. As for the many things we do in emergency medicine, there was no textbook to refer to on how to respond to this specific situation. The city had not experienced riots in almost 50 years, and uncertainty abounded about what would happen next. The emergency department is a place of unpredictability and limited control. We knew what to do: we ran the situation like a code.

These are our lessons learned:

*The public health response must be centralized and coordinated.* Just like a code, it was incredibly important to establish centralized leadership early on. The Maryland Department of Health and Mental Hygiene led daily calls with local health leaders and provided critical support for our local efforts. We opened Baltimore City Health Department emergency operations headquarters to assist with coordinating outreach efforts, to support the other city and state agencies, and to remain “on-call” to respond to critical needs. Just like in a medical code where everyone involved has an established role, we identified the key leaders in the Baltimore City Health Department who would be managing every vital component of our efforts. We held multiple daily check-ins to ensure coordination.

*There must be frequent and effective communication.* Lack of information bred fear and uncertainty, particularly because much of the city experienced the unrest through the more incendiary media coverage. We overcame this by convening daily meetings with every hospital leader, emergency planner, and federally qualified health center director to provide updates on city efforts and get timely feedback on emergency department operations, hospital concerns, and clinic and pharmacy closures. In response to the destruction or closure of several pharmacies, we established and maintained a continuously updated list of open pharmacies and clinics and used our website and social media to spread the word. When it became evident that our message was not getting to the people who needed it most, especially our older adults, we walked door to door identifying people in need of services. We sent informational letters to all physicians in the state

outlining our efforts and specifying how they could direct their patients or provide services. This ongoing regular communication provided a mechanism for the health system to connect with city leaders and our community and kept us abreast of ongoing issues so we could respond appropriately.

*Flexibility and adaptability are critical.* The emergency room metaphor is applicable in other ways. Everyone’s had *that* challenging shift as an attending physician. As soon as the other attending leaves for the night, a “working code” and a “respiratory distress” arrive by ambulance simultaneously. The waiting room is packed, two patients with diabetic ketoacidosis are in the back on insulin drips awaiting intensive care unit consult, and the intoxicated patient in the back hall just required chemical and physical restraints. Similar to a chaotic shift, the ability to adapt, prioritize, and delegate were critical to being able to respond not only to the civil unrest but to making sure daily city health department operations continued, uninterrupted. Within 24 hours after finding out about problems with medication access, we began organizing a hotline to help individuals with prescription access. We eventually distributed more than 200 prescriptions to our most vulnerable residents at this time. Whereas we thought residents would be calling about relocating pharmacies, our telephone communications identified several people who seemed in such extremis over the telephone that we activated emergency medical services to go to their homes and take them to the emergency department. We never knew what could happen but were confident in our capacity and flexibility to respond.

*Be prepared.* The Baltimore City Health Department houses a very capable Office of Public Health Preparedness and Response with trained staff, standard operating procedures, and an action plan in case of emergency. Usually, the office springs into action during times of extreme weather, natural disasters, or epidemics, such as the 2010 H1N1 flu pandemic or the harsh winter conditions of 2014. Although the unpredictability of this situation differed from typical public health threats, these established protocols and leadership allowed us to make use of a robust emergency preparedness framework.

*Closure and debriefing are important.* The period of acute unrest and uncertainty subsided after several days, but just like a post-code team debriefing, it was important for us to connect with our team and partners to provide closure about the events of the previous week. We provided final updates to our hospital leaders regarding our efforts and debriefed staff internally. This was an opportunity to publicly and broadly thank those who donated personal time and energy to Baltimore City Health Department efforts and a forum to think more critically about what we did well and what could be improved.

In this case, we completed a full After Action Report and Improvement Plan, which highlighted our major strengths and primary areas for improvement. The strengths included

interagency communication and service delivery to the most vulnerable. The primary areas for improvement identified were the need for improved communication with state partners and volunteers. There have been several smaller-scale activations of emergency preparedness protocols for key court hearings related to the Freddie Gray case in the months since the state of emergency. We have already begun to implement improved emergency preparedness and response strategies.

## **CONCLUSION**

To continue our analogy of the code, we are fortunate that Baltimore has had a return of spontaneous circulation. The city is working to recover from the damage done during the unrest. More importantly, we are focusing and reenergizing efforts to address the deeply rooted educational, economic, housing, mental health, and physical health disparities that prompted these events.

Will another “civil unrest code” come in? We don’t know and certainly hope not. But we are confident our team will

respond with the same energy, dexterity, and compassion that make us so proud to serve in the Baltimore City Health Department every day.

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