

THE



DEMS

NEWSLETTER

November 1974
Vol. 1, No. 2

Friends—

The Maryland EMS System has made rapid strides in the last few months. Regional Field coordinators have joined the DEMS staff to facilitate communication throughout the state. Six mid-Atlantic states are now cooperating in a coordinated effort to solve interstate EMS problems. Design and implementation of the statewide EMS communication system is well underway. The *Newsletter* gives up-to-date reports on these and other areas of progress.

One of the things that has and will further aid us in our efforts is the Emergency Medical Services Act passed by the Congress and signed by the President late in 1973 with the purpose of providing Federal financial support, technical assistance, and encouragement for the development of better emergency medical services in communities throughout the nation.

The EMSS Act defines an emergency medical services system as one "... which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery, in an appropriate geographical area, of health care services under emergency conditions (occurring either as a result of the patient's condition or of

natural disasters or similar conditions) and which is administered by a public or nonprofit private entity which has the authority and the resources to provide effective administration of the System."

Under the EMSS Act, eligibility for Federal support and assistance includes states, units of general local government, or any other public entity or nonprofit private entity. Three types of Federal grants to establish or improve their emergency systems are available: 1) Feasibility Studies and Planning Grants, for studying the feasibility and operation of an emergency medical services system, and for planning the establishment and operation of such a system; 2) Establishment and Initial Operation Grants; 3) Expansion and Improvement Grants.

Under these grants, HEW is seeking, in each community, the implementation of a plan for a "system, and grant applications will have to demonstrate that there is such a plan."

The EMSS Act requires that where plans are developed and systems established, expanded, and improved with funds under this Act, the recipients of funds must direct their efforts to the following components of a system: the provision of manpower, training of personnel, communications, transportation, facilities, critical care units, use of public safety agencies, consumer participation,

accessibility to care, transfer of patients, standard medical record keeping, consumer information and education, independent review and evaluation, disaster linkage, mutual aid agreements.

Other grants will be available for the training of emergency medical personnel and for some research projects. The Health Resources Administration will administer the training grants through its Bureau of Health Resources Development and the research grants through its Bureau of Health Services Research. To date, for feasibility and planning, \$129,000 in Federal aid has been obtained by Maryland EMS regions. A breakdown of the amounts can be found in the "System Update" column in this *Newsletter*.

We want to know what your EMS group is doing and we want to publicize it in the *Newsletter*. Please send news items, letters, articles, etc., to Mr. John Morris, Administrator. Your input is essential to the success and continued development of the EMS program in Maryland. Let us hear from you.

R Adams Cowley, M.D.

At the Federal level, one Marylander, Senator J. Glenn Beall, Jr., has been instrumental in developing EMS legislation. Senator Beall brought Federal representatives to see the trauma system at work. He introduced EMS legislation in Congress that resulted in the present law. Sen. Beall's commitment to emergency health care has aided the progress of EMS in the state and the nation.

We asked Sen. Beall to share his thoughts with us on the Maryland EMS system. His response follows.

EMS: Progress in Maryland

by J. Glenn Beall, Jr.
U.S. Senate

There is no better example of the gap between what medical science knows and what is delivered to our citizens than in the Emergency Medical Services (EMS) area. Surprisingly, a trauma victim in Vietnam had a better chance of survival than a similar victim here at home. Why? The military in Vietnam perfected its organized system of transporting and treating emergency victims which had been developed during World War II and the Korean War.

The technology and know-how exists to make dramatic improvements here at home. We need only to provide trained personnel, to rationalize and categorize our emergency facilities and services, and to link them by modern transportation and communication. Experts predict such a system would save 60,000 lives annually. Certain actions taken last year are bringing us closer to achieving that goal.

First, the "Emergency Medical Services System Act of 1973" was enacted. This landmark legislation, now Public Law 93-154, authorized \$185 million in grants over a three-year period to state and local

governments and private nonprofit organizations to study, plan, establish, and assist in the initial operations of EMS. Such systems would include adequately trained personnel, communication systems, transportation facilities, treatment facilities, educational programs, and contingency programs to handle natural disasters and mass casualties. Congress appropriated \$27 million to implement the Act.

Secondly, the Baltimore Regional Planning Council received a \$1.2 million grant under the President's emergency medical care demonstration program to develop a metropolitan Baltimore communications network.

Thirdly, the establishment of the Institute for Emergency Medicine at the University of Maryland sparked the movement toward a statewide system.

Maryland has had a headstart in emergency medical care. We have the most sophisticated trauma center in the nation at the Maryland Institute for Emergency Medicine. With the other specialized centers at Johns Hopkins University Hospital and Baltimore City Hospital, Maryland has unmatched capability and excellence.

In addition, a system of rapid transportation has been developed using helicopters operated by the Maryland State Police. When enough helicopters are provided, Maryland citizens, wherever they reside, will be minutes or at the most, not more than the critical hour away from the best emergency care available anywhere.

I am convinced that the ultimate success of EMS depends on the responses and actions by the health community and the state and local governments.

With work and cooperation by all, Maryland will become a model for the entire nation. Since this is an area in which every minute counts, we can move quickly to implement the statewide system at the local, state and federal levels.

NEWS

SYSTEM UPDATE

SYSTEM UPDATE will be a regular feature of the *EMS Newsletter*, noting the progress of the five Maryland EMS regions as they implement the statewide EMS program. Since publication of the last *Newsletter*, the following summarizes achievements of the regions and their advisory councils.

Region I (Appalachian Region):

The Region I EMS Council was instrumental in obtaining the following grants for regional EMS projects: A \$42,500 Feasibility and Planning grant; a \$35,000 grant from the Appalachian Regional Commission (ARC) for the purchase of two ambulances; an \$85,000 grant (with DEMS as the grantee) from ARC for the administrative support of Region I, half of Region II, and the Appalachia Inter-state EMS Consortium. A Cardiac Rescue Technician (CRT) course, supported by a grant from ARC, is planned by local physicians.

An outstanding emergency vehicle driver's course was developed and presented to region ambulance drivers. The planning project was begun with a detailed survey of all ambulance units, current resources and priority needs.

Region II (Mid-Maryland):

Cardiac Rescue Training plans have been endorsed by local physicians and facilities for training are being planned.

Region III (Metropolitan Baltimore):

Initial operation of Region III's communication system which includes approximately 28 ambulances with full telemetry has just begun. Categorization of hospitals is proceeding and a CRT course is now in progress.

Region IV (Eastern Shore):

Region IV is proceeding with the planning process. The Council received a \$45,000 HEW Feasibility and Planning grant.

Region V (Metropolitan Washington):

A \$45,000 HEW Feasibility and Planning grant was awarded to Region V. Six local EMS councils have been formed in Region V. A \$33,000 contract to have the District of Columbia and Northern Virginia participate in the design of a regional EMS communication system was negotiated with the Maryland EMS communications system designer.

Inter-regional EMS Advisory Council (REMSAC)

REMSAC, composed of four representatives of each of Maryland's five regional EMS advisory councils, met for the second time on September 5. Sharing notes on problems and successes, the Council received information on the state-wide program development and provided valuable counsel to the Division staff on program policies and operations. The next REMSAC meeting is scheduled for December 4th.

representatives from the federal EMS program agencies including the Department of Health, Education, and Welfare; the Public Health Service Region III Field Office in Philadelphia; the Appalachia Regional Commission; and the Highway Safety Program of the federal Department of Transportation.

Each state made a presentation of their accomplishments to date in the field of emergency medical services and the federal EMS agencies described the objectives of their programs. The bulk of the discussion centered around the urgent need for all states to coordinate and collaborate so that a complete and effective emergency medical services system, building upon the resources and capabilities of all states, could be established. The attendees unanimously agreed to form a six-state EMS Council composed of one representative from each state. The Council will address those EMS issues that require interstate collaboration, such as: compatible state laws, a unified communication system, reciprocal personnel certification recognition, and shared transportation and facilities capabilities.

The federal program representatives fully endorsed the concept of the Council, offered some means

of providing seed money to assist in defraying Council meeting expenses, and suggested that this Council play a strong role in evaluating EMS projects proposed within the six-state region.

The next meeting of the full membership of the Council is scheduled for December 2-3, 1974 and an executive committee meeting will be held on November 4 to draft by-laws and other organizational procedures.

New Appointment Announced

Dr. George M. Simons was appointed on July 3 to succeed Dr. John B. De Hoff as Chairman of the Committee for EMS of the Medical and Chirurgical Faculty of the State of Maryland.

According to Dr. Simons, the committee's objectives are to develop action programs in EMS designed to meet the state's needs and to maintain liaison with EMS groups at all levels. The committee shall strive for continued improvement in the emergency care provided the patient. It will attempt to coordinate similar activities being carried out by like committees of other organizations.

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MEETINGS

Mid-Atlantic EMS Council Meets

On September 9-10, 1974, Governor Mandel was host aboard his yacht, "The Maryland Lady", to the Maryland EMS staff and representatives from the five states surrounding Maryland who met to discuss interstate emergency medical services problems.

The two-day meeting was attended by two EMS officials from each of the states of Delaware, District of Columbia, Pennsylvania, Virginia and West Virginia, together with the staff of Maryland's Division of Emergency Medical Services. Also in attendance were

COORDINATORS JOIN DEMS STAFF

Five Regional EMS Field Coordinators and a Chief Coordinator have been selected by the regions and hired by the Division of Emergency Medical Services. These coordinators will staff Field Offices located in each region with the responsibility for liaison and coordination with local providers, governments, and citizen groups. Each coordinator will staff the local Regional EMS Advisory Council and assist in the implementation of regional training programs, data gathering, transfer of patients, and other functions necessary to provide a coordinated system of care to the critically injured patient.

Please feel free to contact your regional coordinator regarding all EMS matters.

Chief Coordinator	William E. Hathaway	528-7800
Region I	David Ramsey	334-8111
Region II	Michael Smith	528-7800
Region III	George Pelletier	539-8666
Region IV	Marc C. Bramble	228-8911
Region V	Jeffrey T. Mitchell	528-7800

Pediatric Trauma Treated in Unique Center

by J. Alex Haller, Jr., M.D.

The pediatric trauma center at Johns Hopkins is the first unit designed especially for the delivery of emergency care for children in a university hospital.

The emergency facilities on the first floor of the new Edwards A. Park Building are operational 24 hours a day, and include both surgical and medical components, x-ray facilities, and blood and chemistry laboratories. This unit is organized to provide primary resuscitation and initial management of extensive and multiple injuries in children. It is also staffed to provide the highest quality treatment for simpler injuries and emergency illness for children from the immediate geographical area, the East Baltimore community. Major trauma is the third leading cause of death in the population as a whole, but is the leading cause of death in children. Half of the children who die in the United States in 1974 will die as a result of serious injuries.

The death of a child is always unfortunate, but crippling injuries and the resulting need for rehabilitation may have a far greater impact on society. The expenditure of resources and personnel and the economic loss from termination of work potential are greater than similar losses following injuries in adults. Disability and rehabilitation create difficult adjustments for a mature, stable adult. For a child, these adjustments may be overwhelming when they are added to the natural stresses of growth and development. In 1965, more than 100,000 children were permanently crippled by accidents in the United States, and another two million were temporarily incapacitated by their injuries.

One of our responsibilities, as physicians, as nurses, and as parents, is to bring this problem of trauma into sharper public focus. In this way, we may enlist local and national financial support for studies of accident prevention and management of major injuries.

"Half of the children who die in the U.S. in 1974 will die as a result of serious injury."

A child may be affected quite differently than an adult by the same type of major accident. For example, the loss of a small amount of blood in a young child assumes dramatic importance when we consider his smaller blood volume. Congenital abnormalities, especially heart defects, are more likely to be present in a child and may complicate the treatment of his injuries.

Blunt impact accidents are responsible for the majority of serious injuries in children. In such injuries, external evidence of internal damage may be absent or misleading and result in serious delays of proper treatment.

Serious injuries in a child may have disastrous effects upon his emotional well being at this impressionable age. The terror of separation from familiar faces is magnified for the child who is brought to the impersonal environment of a busy adult emergency room. Most emergency room personnel are not fully aware of this additional emotional injury to a child which may result from the sights he may see in an adult

emergency room. Anyone who has seen a child being sutured next to a bloody, swearing adult or pushed aside to transport a dying gunshot victim can imagine the memories which must follow. Unless this environment gives *better* care to an injured child, we believe it should be eliminated.

We have, therefore, embarked upon an innovative program for the delivery of emergency care to children which we hope will serve as a regional trauma center for this unique group. Children brought into this unit have the advantages of centralized diagnostic facilities and of specialty consultation in all surgical and pediatric disciplines. In addition, they are treated in an environment designed especially for them.

We believe that these concepts can be best translated into an operational program in a university hospital environment with a geographically distinct trauma center for initial management of serious injuries and with an adjacent children's intensive care unit which also provides postoperative care for children.

Many types of injuries are managed in the trauma center; poisonings and caustic burns from ingestion of toxic substances, electric shock and flame burns, machine injuries such as wringer, bicycle and power mower injuries, battered children, sports injuries from competitive athletics, drownings, and injuries resulting from major automobile accidents.

A child with multiple or major injuries is delivered by ambulance or helicopter to the trauma evaluation room. Because of the limited reserves of small children the rapidity with which they may deterior-

ate, transportation of an injured child assumes increased importance. This requires special training of ambulance and helicopter personnel in resuscitation of infants and simplified techniques of treatment in transit.

Neither the Children's Trauma Center Program nor the facility is designed to compete with other excellent emergency facilities in the Baltimore area which can manage routine injuries and illnesses of children. Rather, this center supple-

ments available care in other community hospitals and thereby prevents expensive and often unreasonable duplication of highly specialized techniques for the management of major injuries in children.

With this type of organizational framework and a physically separate trauma unit for children, we believe improved teamwork and more efficient management of multiple injuries will result. The basic principles of rapid, careful

evaluation and sequential correction of altered physiology remain the backbone of successful therapy in children. The unique metabolic demands and miniature anatomic relationships, especially of a small child, present the physician with a special challenge and a great responsibility. Rewards for the successful management of multiple trauma are high; for the younger the injured child, the greater is our total investment in his welfare and in his future.

Intensive Care in Transit

Montgomery County recently began operating two Mobile Intensive Care Units (MICU) providing the latest medical care in an emergency vehicle and the first of its kind in the Washington Metropolitan area.

Unlike regular ambulances, the vehicles are staffed by paramedics and equipped with sophisticated life support services. They have the capability to administer intravenous fluids and drugs and perform EKG heart monitoring and defibrillation to stabilize failing hearts. The units will each be staffed with a three-member team including trained volunteer and career paramedic personnel certified by the State Board of Medical Examiners, with 65 paramedics already trained and approved.

The MICU's will be dispatched on major life-threatening incidents such as heart attacks, automobile accidents, electrocutions, serious burns, gunshot and stab wounds. Paramedics can maintain radio communication while on the scene and enroute with physicians at any of the County's four hospitals. Physicians will advise on the medical treatment to be provided.

Thirty fire departments and rescue squad ambulances answer 30,000 emergency medical calls in

Montgomery County annually. Officials estimate that 10,000 of those patients will benefit directly from the MICU operations as a result of the new specialized medical care.

County fire and rescue authorities anticipate that the MICU operation can save 100 lives a year and that 900 persons will experience fewer medical complications and a shorter hospital stay because of the MICU program.

The first two MICU's will be stationed at the Bethesda-Chevy Chase and the Wheaton Rescue

Squads but will provide service throughout the County. A third MICU scheduled for delivery in the next few weeks will be stationed at the Public Training Academy in Rockville.

The vehicles were manufactured by Atlantic Research Corporation of Springfield, Virginia, at a cost of approximately \$20,000 each. The medical and communication equipment was obtained from the Telecare Corporation of Houston, Texas, at a cost of approximately \$20,000 per vehicle.



Montgomery County's new mobile intensive care units: below, an outside view; left, crew members inspect equipment inside the unit. Montgomery Journal photos by Hoke Kempsey.



(continued from page 3)

Physicians Group Established

A Medical Management Consultant Group has been established by the Director, EMS, to assist him in determining medical needs in the delivery of emergency medical care that require further study and implementation. Members were selected on the basis of specialty area, geographic location, and representation of organizations involved in EMS. Members of this group are: Dr. Robert Wilder, Dr. Wallace Sadowsky, Dr. Donald Wenger, Dr. Donald Gann, Dr. John Clark, Dr. Herman Risenberger, Dr. Leonard Scherlis, Dr. A. Gibson Packard, Dr. Ernest Austin, Dr. Richard Myers, Dr. Peter Fahrney, Dr. Elliott Fishel, Dr. John Stafford, Dr. Sam Seeley, Dr. Benjamin White, Dr. John Harvey, Dr. Paul Joliet, Dr. Gina Glick, Dr. Robert Adkins, Mr. Larry Lawrence, Dr. Nathan Schnaper, Agnes Kemerer, R.N., and Dr. Russell Fisher.

The following organizations are represented in this group: American Heart Association; American Academy of Orthopaedic Surgery; American College of Emergency Physicians; Maryland Hospital Association; Trauma Committee, American College of Surgeons; County Health Officers, Maryland; Department of Health and Mental Hygiene; Baltimore City and County Fire Department Training; American Trauma Society; and Critical Care Medicine.

The first meeting of this group was held on September 19. A brief history of the Maryland EMS Program and the efforts made in this field were presented. Task Forces

established were: Categorization Committee - Chairman, Dr. J. Harvey; Medical-Legal Committee - Chairman, Dr. D. Wenger.

The Medical Management Consultant Group will meet every two months. Recommendations derived from this group will be published in upcoming issues of the *EMS Newsletter*.

TRAINING

CRT Training Programs

The Cardiac Rescue Technician (CRT) Program for Region III is now projected for full operation by late autumn. Delays have been caused by late arrival of ambulance and base station radio equipment. When operational, advanced life support will be provided from 28 ambulances in the region, including ECC monitoring, radio telemetry and voice communication, defibrillation, and limited drug administration.

Training has proceeded steadily in large part due to the efforts of Dr. Gus Voight. Following the pilot program he developed at Baltimore City Hospital, additional programs have been conducted at Sinai Hospital and University of Maryland Hospital. Recently, several community colleges have expressed interest in participating in training and one course is underway at Harford Community College through the efforts of Dr. John Stafford. CRT courses began at Sinai and Baltimore City Hospitals on October 14 and will begin every sixth week through June 1975.

Training is not limited to Region III. Current programs also exist in Montgomery and Allegany Counties. Approximately 250 men throughout the state have been certified by the Board of Medical Examiners.

In order to help facilitate future training in the state, the Division of Emergency Medical Services (DEMS) has under considera-

tion recommendations of current CRT instructors concerning objectives, course content, recertification, and instructor training. It is the goal of the state to provide a standard CRT training program throughout Maryland.

Cooperative Program for Student Nurses Planned

The Maryland Institute for Emergency Medicine will cooperate with the Anne Arundel Community College School of Nursing this spring to provide clinical experience for a select number of students. The college has developed the program to help bridge the transition from student to professional nurse. Similar in concept to an internship, the program offers particular promise for critical care units.

During the final five weeks prior to graduation, each student is given a clinical assignment in an area she has identified as one in which she would seek employment. Student, faculty and clinical staff work together toward achieving specific objectives for the experience. The student acquires confidence, experience and familiarity with the philosophy of the area while still under the aegis of the college. The prospective employer gains knowledge of the needs and potential of the student. The program appears successful where it has been implemented in other areas of practice, including intensive care units.

The Nursing Program for EMS

Five groups of nurses are integrally involved in emergency or critical care nursing within the Maryland health care system. These are the emergency room nurse, the intensive care nurse, the coronary care nurse, the operating room nurse and recovery room nurse within the hospital. Outside the hospital, the industrial nurse plays a vital role as do the educators in

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R ADAMS COWLEY, M.D. - Director
C. W. Garrett - Associate Director
John W. Morris - Administrator

schools of nursing and participants in staff development programs and EMT and CRT training programs.

The patient who is likely to receive the best care upon admission to the hospital anywhere in the state is the coronary patient. Due to an organized educational and training program developed by the Heart Association, the coronary care nurse is performing at an unusually high level of expertise.

This same standard of care can be applied to the emergency room, the intensive care unit, and industrial clinics if similar programs are developed.

Five nurses are soon to be added to the Division of EMS staff. These nurses will be chosen on the basis of specialization and their expertise in solving the major problems facing nursing in emergency

health care delivery, including pediatric emergencies, cardiovascular emergencies and trauma. The nurses selected will be based centrally and will conduct workshops, establish educational programs and seminars, establish guidelines for standards of practice and, by invitation, work collaboratively with nursing service administrations to increase the knowledge and skill of all nurses involved in emergency care.

With the current efforts to reduce the numbers of residents and the need for cost containment, the nurse will assume a more vital role in the delivery of emergency care. Through education, the highly motivated nurse can become an even more valuable member of the emergency or critical care team.

the physician will assume responsibility for the CRT's insertion of the device by issuing direct or standing orders for its use.

NEWS ITEMS

Use of Esophageal Airways

The national literature presents contradictory evaluations of the usefulness and safety of esophageal airways. Some writers praise the device while others condemn it. However, all agree that the device can be dangerous if applied improperly.

The Maryland Institute for Emergency Medicine is currently involved in an evaluation of the esophageal airway that involves field use as well as a clinical, in-house protocol. Upon completion of this study, definitive recommendations regarding training and use will be made.

Until then, the Division of Emergency Medical Services recommends that the esophageal airway *not* be used by emergency medical technicians or ambulance attendants with lesser training.

A certified Cardiac Rescue Technician (CRT) may use the device if a physician will take responsibility for certifying that the CRT is proficient in its use, and if

American Trauma Society Maryland Division Formed

On May 9th a buffet dinner was given by Governor Mandel, Honorary Chairman of the Maryland Division, to gain the backing of leaders from the medical and lay community. From this group, a Board of Directors was derived consisting of 15 physicians and 15 lay leaders.

The main effort of the Maryland Division has been the preparation for a kick-off dinner which will be held on November 8th at the Blue Crest North, 401 Reisterstown Road, Pikesville, beginning at 6:30 p.m. with cocktails. The cost is \$50 per ticket (tax deductible).

This affair is being held in an effort to establish the identity of the American Trauma Society and to provide recognition for its efforts at the national as well as local level. The proceeds of the banquet will be used to establish a

*American Trauma Society
Maryland Division
Banquet*

*November 8, 1974
6:30 p.m.*

*Blue Crest North
401 Reisterstown Road
Pikesville, Maryland*

\$50 per ticket

Division Office with an Executive Director which should enable the Maryland Division to get off the ground.

For tickets, please contact Miss Sandra Bond, at 301 - 528-6846.

As of this date, there are 56 founding members from Maryland. Founding memberships close May 1, 1975 and information and applications can be obtained from Dr. Cowley's Office.

Spreading the Word

Public information and education in the area of EMS are primary concerns of the Maryland Institute for Emergency Medicine. As a continuing effort in that direction, MIEM sponsors a public information booth complete with a sound/slide program and educational literature.

The booth was most recently a featured attraction in Fredericktowne Mall in conjunction with Frederick County's Emergency Services Week, September 23-28. The Frederick helicopter and crews were also available and window displays and posters emphasized the importance of EMS.

The public information booth was also enthusiastically received at the 82nd Fireman's Convention in Ocean City on June 16-19.

The public information booth is available to other organizations by request. For more information contact the Division of Emergency Medical Services.

EMSCS: Status Report

The Division of Emergency Medical Services has contracted with Spectra Associates, Inc. of Cedar Rapids, Iowa, for consulting services during implementation, planning, installation and test of a statewide EMS Communication System (EMSCS).

The EMSCS will provide complete intercommunication among ambulances, hospital physicians, Medivac helicopters and other emergency facilities and vehicles statewide, and within border areas of other states. System coordination will be provided at the state Systems Communication Center (SYSCOM) located in the Maryland Institute for Emergency Medicine in Baltimore.

Thus far, Spectra Associates, Inc. has completed a thorough survey of existing EMS communications and facilities throughout the state and has completed the preliminary system design. Spectra is currently developing a communications design and selecting the appropriate system for each region. Regional representatives have been briefed on system configuration for their regions.

Region III's communication system is scheduled to go operational at the end of November.

The final design completion goal is November 1.

CALENDAR

STATE

- Oct. 29
10 a.m. Prince Georges County EMS Advisory Council
Prince Georges General Hospital, Cheverly, Md.
- Nov. 1 Executive Committee of Mid-Atlantic EMS Council
- Nov. 12
7 p.m. Mid-Maryland Region EMS Advisory Council
Frederick, Md. (663-8300 ext. 250)
- Nov. 14
7 p.m. Montgomery County EMS Advisory Council
611 Rockville Pike, Rockville, Md.
- Nov. 16
10 a.m. EMS Technical Advisory Council (EMSTAC)
Anne Arundel Fire Academy, Millersville, Md.
- Nov. 20
Appalachia Region EMS Advisory Council
McHenry, Md. (724-1616)
- Nov. 26
4-6 p.m. Medical Management Consultant Group
DEMS Conference Room
- Dec. 2-3 Mid-Atlantic EMS Council
- Dec. 4 Statewide Regional EMS Advisory Council (REMSAC)
Eastern Shore (528-6846)

NATIONAL

- Oct. 31 -
Nov. 2 Ambulance Assoc. of America and National Ambulance
and Medical Supplies Assoc. Joint Convention.
Denver, Colorado. (Ted M. Shearer, Ambulance Assoc.
of America, Think Bldg., 1377 Ashley River Rd., No. 4,
Charleston, South Carolina 29407.)
- Nov. 1-3 Annual Scientific Assembly, Crisis Medicine.
White Sulphur Springs, West Va.
(Registrar, Medical Society of the District of Columbia,
2007 Eye St., N.W., Washington, D.C. 20006)
- Nov. 4-6 American College of Emergency Physicians Scientific Assembly.
Washington, D.C. (Karl G. Mangold, 241 E. Saginow St.,
East Lansing, Mich. 48823)
- Nov. 15 New Health Practitioners - Partners in Patient Care. Workshop.
Chicago, Illinois. (Institute of Medicine of Chicago,
332 S. Michigan Avenue, Chicago 60605.)
- Dec. 23 -
Mar. 6 Winter Cruises/Workshops on "Emergencies in Medical Practice."
(Seminars and Symposia, Inc., 505 Park Ave., N.Y. 10022.
212-421-3774)

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Address Correction Requested

