A clipboard binder containing an ambulance runsheet and related material will be given to each ambulance participating in the program.

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Revised Runsheet Ready for Field Use

Computerized ambulance runsheets with a simplified and standard-sized format will be introduced to prehospital care providers starting this month.

The original version of a machine-read runsheet, first used in 1982, was redesigned during the past year in response to concerns raised by prehospital personnel and suggestions from the REMSAC runsheet committee. Use of the new computerized runsheets has definite advantages for prehospital personnel, as well as for patients.

The changeover to the new runsheets will be implemented region by region, according to Lou Jordan, associate director of prehospital care.

"We will probably start in Region III because that is where the utilization of the first automatically read runsheets has been the highest and where the greatest number of calls for emergency medical help occur [in the state]," said Mr. Jordan.

MIEMSS, with the help of many prehospital providers, has prepared instruction booklets and a slide/tape program to help teach prehospital care providers how to fill out the new runsheets. These materials will be provided free of charge to the jurisdictions that decide to use the runsheets. Mr. Jordan said each jurisdiction will be responsible for training or retraining its prehospital personnel.

The chief complaints heard from prehospital care providers concerning the original computerized runsheet were that it had too many spaces to fill out and that it was cumbersome to use in the field because the large section for handwritten comments made the form too big.

For that reason, the incident and census box numbers can be written out on the new form, instead of filling in circles, as was necessary on the old form. In addition, the right/left designations have been dropped from the section of the new form where the location and type of injury are recorded. The new form has only enough space to record vital signs twice, compared to four times on the old form, and medications and electrocardiogram rhythms once, compared to six times for each item on the old form.

Reducing the amount of space required for these items made it possible to include a small section for comments on the new runsheet, which is a standard size — 8½ by 11 inches.

The old runsheet was twice that size because the comments section was as big as the machine-read part of the form. This nonstandard-sized runsheet had to be folded and unfolded, and turned back and forth to record information on it. Moreover, prehospital care providers felt compelled to fill up the comments section.

The comments section on the new runsheet is too small to be imposing, but is big enough to record additional measurements of vital signs, administrations of medications, observations of electrocardiogram rhythms, and other notes about the prehospital care that was provided.

When prehospital care providers do need additional room to write their comments, a separate 8½ by 11-inch form will be available. This form requires less identification information at the top than did the comments section of the old runsheet.

By condensing the space required for certain items of information, it also was possible to include new items of information on the new runsheet. For example, there are places to write in the patient's name and address and the location of the incident.

In addition, several new categories were added to the sections: illness/emergency, care, and type of call. If the prehospital care provider obtained consultation, the hospital and physician's name must be identified. The reason for taking the patient to the chosen receiving hospital must also be specified and the signature of an authorized hospital employee must be obtained at the time the patient is delivered to the receiving hospital.

The new items of information labeled priority, exceptional call, radio, and mileage may be of special interest. Priority refers to the urgency with which the patient needed to be treated. This information will help guide triage decisions.

Marking the exceptional call circle calls attention to cases in which the prehospital care provided fell outside of the normal standard of performance, or in which prehospital care was performed at

(Continued on page 3)

Region II Holds Disaster Drill

A disaster drill involving "victims" from an explosion was recently held at Myersville Elementary School in Frederick county. More than 50 people lay on the cafetorium floor while fire and ambulance companies from both Frederick and Washington counties responded. Victims had burns, impaled objects, blunt trauma, and eye and ear injuries. (Photos courtesy of "Frederick County Volunteer Fire and Rescue News.")

Poison Center Marks 30th Anniversary

This year marks the 30th anniversary of the Maryland Poison Center. In 1954 when Maryland's first poison centers were established at the University of Maryland and the Johns Hopkins hospitals, poison control centers were a revolutionary concept in medical care.

Today the Maryland Poison Center, a division of the School of Pharmacy of the University of Maryland at Baltimore, is a mainstay in Maryland's emergency medical care system. Recognized both regionally and nationally for its expertise, it provides toxicity and emergency treatment information daily on a 24-hour basis.

Certified as a regional poison center by the American Association of Poison Control Centers, the Maryland Poison Center handles over 55,000 poison-related calls annually. These calls concern materials that run the gamut from the potentially fatal to the nontoxic—from caustics to soap suds. Many of the calls concern incidents involving children under five years of age and are not serious. But the poison center staff point out that in many cases they could have been prevented.

This year the Maryland Poison Center staff are using the national subtheme, "Distractions can be disastrous," to emphasize that even a brief interruption — a phone call, a doorbell, a visitor — can be long enough for a child to be poisoned. This ties in with the center's educational focus which stresses poison-proofing the home. If household products and drugs have been properly closed and stored out of reach, a child will not have access to a potential poison.

Checklists to help with locating potentially harmful items and sheets of MR. YUK stickers are available to anyone who sends a self-addressed, stamped business envelope to: PPW-84, 20 N. Pine St., Baltimore, MD 21201. For further information, contact Jacquie Lucy, (301) 528-7184.

Trauma Management

A trauma seminar on current trauma management principles for the prehospital care provider will be offered by the Maryland Fire and Rescue Institute and Essex Community College on March 31 and April 1 at Essex Community College. Preregistration closes March 19.

For information, call MFRI at (301) 454-2416.

Task Force to Review EMT-A Program

The 19-member EMT-A Task Force was organized several months ago to review ways of improving Maryland's EMT-A program. It was formed at the request of the DEMSPAC or the Director's EMS Prehospital Advisory Committee (formerly the Ad Hoc Committee on Testing/Training/Certification). It is composed of representatives from fire/rescue/EMS organizations, medical directors, and EMS advisory councils, with several ex-officio members from MIEMSS and MFRI. Administrative support is provided by Touche Ross Co. and funded by MIEMSS.

Since December 21, the full task force has been meeting biweekly, with each of its three subcommittees meeting as frequently but at different times.

According to Chief M. H. (Jim) Estepp, of the Prince Georges County Fire Department, who is chairman of the group, the EMT-A Task Force has been trying to "identify the problems with the EMT-A program that disillusion people." The task force has solicited comments, concerns, and ideas for program improvements from Maryland EMT-As. It has also looked at the EMT-A programs in other states and has picked out salient points that would be helpful in improving Maryland's program.

The three subcommittees addressed some of the following topics.

The testing and certification/evaluation subcommittee, chaired by Frank T. Barranco, MD, departmental surgeon of the Baltimore County Fire Department, examined the failure rate of EMT-A students and the level of expertise needed to pass the final evaluation for certification; the number and cost of evaluators needed for EMT-A testing; and the "evaluator vs. instructor" problem regarding differences in techniques for patient management.

Leonard King, second vice-president of the Maryland State Firemen's Association, chaired the subcommittee on training programs. It was concerned that many students report that the EMT-A course is not long enough to provide sufficient time to master the material; yet jurisdictions and students cannot afford the cost or time to lengthen the course. The subcommittee also looked at the requirements for an EMT-A instructor and the fact that there seems to be an increasing shortage of instructors.

However, its main concern has been the EMT-A curriculum. According to Chief Estepp, the subcommittee is hoping that the EMT-A program can move toward more standardization, especially in course content and in the instruction manual, as well as toward uniformity in training. The subcommittee is reviewing the EMT-A curriculum and course materials that were recently revised by the U. S. Department of Transportation (DOT). The DOT program for EMT-As is used as the basis for a national standard by many states. The subcommittee has also been looking into a combination training/working program for EMT-As.

Examining the role of state agencies, the subcommittee chaired by Leon Hayes of Region V discussed the numerous requirements of state agencies that prevent jurisdictions from training small groups as needed (for example, as replacement career employees). Due to various reasons the number of new and recertified EMT-As appears to be dwindling.

The full task force is now evaluating its material and making recommendations in preparation for its first draft written report. According to Chairman Estepp, "this draft will be widely circulated here in Maryland." Once this process has been completed, the task force will finalize their recommendations and will submit a report to Dr. R Adams Cowley, Director of the State EMS System, for his action. It is hoped that this process will allow enough time to implement changes for the new training year that begins in July 1984.

— Beverly Sopp

New Runsheet Easier to Use

(Continued from page 1)

an exceptionally high standard or under unusual circumstances. When this circle is filled in, the information on the runsheets and on the comments form will be reviewed by the local jurisdiction.

Whenever radio contact is attempted, the radio section should be marked to indicate the quality of the radio communications from the scene of the emergency. This information will assist the MIEMSS communications office in identifying and correcting weak spots in the statewide EMS communications system.

Finally, the mileage section will help ambulance companies keep track of mileage information. However, prehospital care providers should continue to follow the mileage-record policies of their companies or local jurisdictions.

Perhaps most important of the new items of information on the new runsheet for individual prehospital care providers is the designation of each crew member by an identification number and a corresponding code number: one, two, or three.

These numbers appear next to the following prehospital care items on the runsheet: medications given, intravenous lines attempted and successful, defibrillation attempted, esophageal obturator airway inserted, MAS trousers applied, and vital signs monitored.

By marking these numbered identification circles properly, CRTs will be able to document that they have met their recertification requirements. The Maryland Ambulance Information System computer will keep running tabulations on how many times each CRT has performed a specific skill.

All prehospital care providers benefit from using the new state ambulance runsheet because it is a legal document that gives a detailed account of the prehospital care provided to every patient. A prehospital care provider, named as a defendant in a lawsuit, could use the information on a runsheet as evidence that he or she acted appropriately in the particular case in question.

It is essential, therefore, that all of the information called for on the runsheet is provided and that the information is accurate, Mr. Jordan said.

The benefits of the new ambulance runsheets to patient care are obvious. The physicians at the receiving hospital use the information on the runsheet to decide how to treat the patient initially. Runsheets therefore ensure continuity of care between the field and the hospital.

The information on the runsheets also is stored in, and tabulated by, a computer to provide the hard data needed to evaluate prehospital medical care and EMS services. Patient care is improved continually by implementing changes to correct problems and deficiencies that are identified in the analysis of these data.

The REMSAC runsheet committee hopes the improvements that have been made in the computerized runsheet will increase the usefulness of the management and clinical summaries of runsheet data that are compiled monthly for the jurisdictions in Maryland that use the runsheets.

— Dick Grauel

'EMS News' Clarification . . .

In "Evaluating EMS Systems, Trauma Registry," which appeared in the January issue of this newsletter, we mentioned that the statistical management reports containing ambulance runsheet data helped to justify an additional vehicle for the Hereford area. To ensure that no one misinterprets any statements in the article as critical of the prehospital providers in Hereford, we offer a clarification of our statements and thank Bill Schmalzer, president of the Hereford Volunteer Ambulance Association for his assistance. Italicized statements are from the original article.

In northern Baltimore County, a non-transport vehicle, driven by an ACLS-trained field supervisor, was put into service about seven months ago.

One should not imply from this statement that the unit is a one-man unit. In fact, it is manned by a paramedic and a CRT.

Management reports for Baltimore County clearly showed that EMS coverage was inadequate in the county north of Shawan Road. Formerly, this area was served only by a single ambulance, stationed at the Hereford Volunteer Fire Company.

The need for an additional vehicle was proven by the fact, obtained from the management report, that it took Hereford's ambulance 45 to 90 minutes to respond to a second call when it was already in service.

The phase "EMS coverage was inadequate" does not refer to quality of care or equipment. The ambulance involved is equipped with a Thumper, KED extrication device, pediatric MAS trousers, cardiac monitoring equipment, and other items needed for optimum emergency treatment.

The ambulance, although stationed at the Hereford Volunteer Fire Department, is operated by the Hereford Volunteer Ambulance Association, an ambulance company totally independent for the past 30 years.

The 45–90 minute response time noted in the article referred to the time it took the ambulance to arrive at the emergency scene of the second call. We are reminded that Baltimore County policy requires one to respond by radio by calling "out of service—responding" within three minutes of being alerted. If the Hereford ambulance would not call within three minutes, the second unit would be automatically alerted to respond. Since Hereford's ambulance serves 150 square miles of area and the time it takes to reach the nearest hospitals averages 30 minutes driving time one way, average ambulance runs exceed 1½ hours.

Hereford Volunteer Ambulance Association answers more than 500 calls per year, and they provide a valuable community service.

Address Changed?

Address changed? EMTs and CRTs are encouraged to let their regional offices know their new addresses.

Region III Administrator

George Pelletier, Jr., has been named Region III administrator for MIEMSS. Region III consists of Baltimore City, and Baltimore, Anne Arundel, Harford, Howard, and Carroll counties.

Mr. Pelletier returns to MIEMSS after being the ambulance program coordinator for the Baltimore City Health Department.

Prior to that he was chief regional coordinator and also Region III coordinator at MIEMSS. In the late 1960s, he worked on developing the model for the statewide EMS communications system.

Systems Approach Developed For Behavioral Emergencies

The statewide implementation of a systems approach to behavioral emergencies, addressing both the prehospital and inhospital phases of patient care, is currently underway in Maryland. The program is funded by the Department of Health and Mental Hygiene, and is coordinated by that department and MIEMSS.

Emergency care for phychiatric patients has historically lagged behind care in other medical categories, in part because it is so difficult to envision. "It is easy to see that traumas such as burns and automobile accidents are life and death situations, but somehow behavioral problems seem less threatening," said Peggy Trimble-Bullock, associate director of nursing at MIEMSS who is working with the program. Robert Cumming, MD, associate director of the Mental Hygiene Administration, is director of the inhospital phase of the program, and Paul McClelland, MD, director of psychiatric services at MIEMSS, directs the prehospital segment.

According to Dr. Cumming, the objectives for the program are: to reduce the number of inappropriate hospitalizations; to provide role models for crisis intervention and patient management; to maintain a statistical accounting of psychiatric admissions; and to provide ongoing education for providers on psychiatric issues.

Funds have been allocated for a part-time nurse liaison to the program, Antonia Fuller, RN, MS. Ms. Fuller is coordinating general workshops and individual emergency department training programs around the state.

Psychiatric liaison nurses, trained under the program in education and nursing management, are already working in some hospital emergency departments, coordinating care and training other staff in the appropriate handling of psychiatric emergencies. Hospitals with liaison nurses already practicing include Sacred Heart, Frederick Memorial, Johns Hopkins, Calvert Memorial, Kent/Queen Anne's, Peninsula General, and Easton Memorial.

In addition to training for liaison nurses, the behavioral emergencies program provides comprehensive workshops on managing patients with psychiatric emergencies for law enforcement personnel, prehospital personnel, emergency department personnel, and mental health care providers. The workshops focus on shared problems in treating the mentally disordered patient, and offer a sense of the differing disciplines working together to provide consistent quality care. Another set of workshops is geared strictly to prehospital providers.

Dr. McClelland, who directs the prehospital phase of the training program, said his goals are to ensure that victims of behavioral emergencies are treated as effectively as victims of other traumas. He said he also hopes to see the formation of viable ties between MIEMSS, the Mental Hygiene Administration of DHMH, and the Department of Psychiatry at the University of Maryland Hospital.

The prehospital workshop for ambulance personnel has been developed and delivered by Jeffrey Mitchell, PhD, instructor in the MIEMSS/UMBC emergency health services program. Training for police officers is provided by Richard Hann, MA, a Baltimore County police officer and psychologist. In addition, more generalized workshops have been presented utilizing these speakers as well as

(Continued on page 5)

State Policeman Invents Rescue Rope

When Sgt. Carl Marshall was assigned to the Maryland State Police Aviation Division in 1972, there was no definitive method of making rescues from the air. Whenever a water accident or fire made such a rescue necessary, attempts were made to tie a rope around a part of the aircraft, drop the line to someone in distress, and lift them up and away from danger. There was no set procedure for the maneuver.

So Sgt. Marshall, who prides himself on "always tinkering around and making one thing or another," set out to develop a safe, standard method of aerial rescue. The ensuing 50-foot rope and attached "horse collar" device proved to be a quick, safe way to pick someone up and provide a quick disconnect once the victim reached safe ground. Sgt. Marshall presented his design to Maj. Gary Moore, the commanding officer of the aviation division, who accepted the idea, made it mandatory equipment on every Bell Jet Ranger, and included training in its use as an integral part of the aviation program.

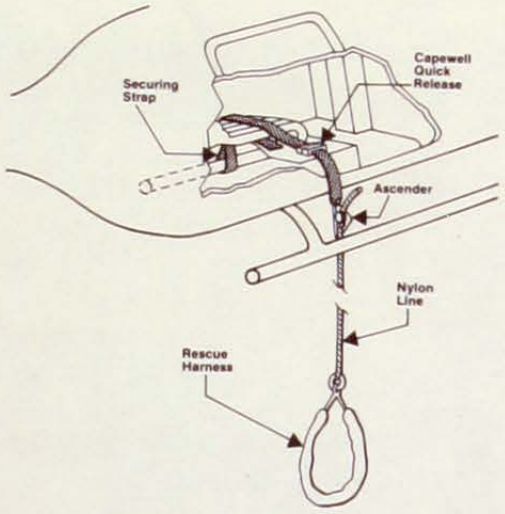
Within weeks after the aerial rescue system became operational in March 1978, three victims of a canoe mishap were sighted clinging to vines and branches near Harper's Ferry. Aviation personnel rigged their helicopter for the life-saving procedure, and all three were saved.

The system is used only as a last resort, in life-threatening situations, primarily when a victim is stranded in an all-encompassing fire, or is clinging for life following a water accident. Since the victim must be able to put the collar around his neck and under his arms, he must be fully conscious despite the imminent danger. According to Lt. George Wyatt, assistant aviation division commander, "the rescue device is never used to lift the victim more than several feet in the air."

"Many of our calls come from fire departments who depend on us to assist when they cannot reach a victim in their rescue boats," Sgt. Marshall noted. Then we fly overhead, assess the situation, and whenever possible, lift the stranded to the nearest accessible safe spot."

During the rescue attempt, the medic constantly gives directions to the pilot, verbally assessing and reassessing the situation until he believes the drop can be successfully made.

When the medic decides the time is right, he drops the rope and belt out of the helicopter, and continues to direct the pilot. The victim is never carried any farther than is necessary.



"After the rescue, we stay in the area of danger, just in case we are needed for further transport," Marshall said, "or in case a rescue boat or police vehicle cannot reach the victim." In the five years since Sgt. Marshall developed the rescue rope, it has been used about 15 times, and in each case the victim would have perished without it.

Since Sgt. Marshall's design became operational five years ago, many state and local police departments, including several as far flung as Nevada and California, have adopted Sgt. Marshall's rescue system. Some have bought the rope directly from a supplier in Baltimore, and others have fashioned their own from Sgt. Marshall's plans.

— Rochelle Cohen

The aerial rescue rope (left) developed by Sgt. Carl Marshall is now mandatory equipment on all Maryland State Police Bell Jet Rangers. The harness on the device provides a quick way to pick up victims and move them to a safe area nearby. Training in the use of the rope (right) is now an integral part of the aviation program.

Behavior Problems Addressed

(Continued from page 4)

Susan Nathan, assistant attorney general for the Mental Hygiene Administration, who discusses the legal requirements regarding psychiatric emergencies, and Bruce Regan, MD, assistant director of the Mental Hygiene Administration, who explains how to manage the difficult patient.

In explaining the need for prehospital training, both Dr. McClelland and Dr. Cumming noted that police officers and paramedics face the similar dilemma of walking into situations where they don't know the territory, to serve their communities. "In essence," Dr. Cumming said, "they're always on the spot."

"Many of the behaviors that police and paramedics encounter are dysfunctions of the brain and not psychiatric occurrences. They may be caused by substance abuse, stroke, seizure, trauma, or medication toxicity," Dr. McClelland said. "Recognizing this, we can save more patients and provide more appropriate therapies."

Dr. McClelland said he believes that the climate is right to be working on this program, since attitudes toward mental illness have changed and the need for treatment for these victims is recognized. "Maryland is ideally suited for this program since the Mental Hygiene Administration is willing to support this effort. Also, we have the best statewide emergency medical system in the country, fully capable of providing the training and expertise necessary to run a comprehensive program."

For further information on the psychiatric emergencies workshops contact Ms. Fuller at (301) 528-3930. For information on prehospital psychiatric care call Dr. Mitchell at (301) 455-3224 (ambulance personnel) or Richard Hann at (301) 828-1375 (police officers).

— Rochelle Cohen

Majerus Heads Army Medical Company

For the past 14 years, Thomas C. Majerus, director of pharmacology at MIEMSS Shock Trauma Center, has had a part-time life away from his responsibilities in the critical care medicine department of MIEMSS. For the past 5½ years, he has had a second identity. One weekend out of four and for two weeks during the summer, he is Major Majerus, commanding officer of the 111 members of Company B (Med), 58th Support Battalion of the Maryland Army National Guard.

The company is made up of many health care providers including EMTs, nurses, physicians, medical technicians, and several other professions and trades. Theirs is the only medical company in the Maryland Army National Guard, and is prepared to provide a full range of support services to a brigade (group of battalions) including emergency care, medical support, medicine, and medical supplies. It is, according to Dr. Majerus, "a big responsibility."

To help manage that responsibility most efficiently, while staying within U. S. Army guidelines, Dr. Majerus has patterned his company's organization closely after MIEMSS.

"The MIEMSS influence includes a medical team headed by physician officers, nurses, and medics, whose protocols closely parallel those of the Shock Trauma Center," Dr. Majerus said.

Additionally, the flow chart, depicting procedures for treating the wounded, shows the patient moving from an aid station to a clearing station via ambulance where the medical "team" is, and then on to a combat support hospital (such as the 136th CSH of the Maryland Guard) or a MASH unit.

"Unlike other National Guard medical companies, Maryland's system utilizes army medics as more autonomous first-responders. This gives more flexibility since the medics can treat, as well as pick up the patient and transport him to a facility," Dr. Majerus explained. "In other units, the initial triage occurs after the patient has already been transferred." Radio communication between field personnel and doctors at the clearing station is another feature based on Maryland's EMS system. "We have been able to streamline our procedures allowing for a much more efficient operation," Dr. Majerus said.

Dr. Thomas Majerus

During the 1981 annual training at Fort AP Hill, Virginia, the new system was put to a rigorous test when nearly 800 guardsmen suffered heat-related injuries during training when temperatures registered over 100°F. The teams and support systems went into action, proving that under actual emergency conditions the system worked.

Dr. Majerus said he enjoys time spent with the Maryland Army National Guard as a change of pace, and a chance to get to work with many different kinds of people he might otherwise never meet. He added that EMS providers might find the Army National Guard another area in which to utilize their skills and provide worthwhile service to their community and country.

For more information regarding membership opportunities in the Maryland Army National Guard, call (301) 823-7351.

— Rochelle Cohen

Company B (Medical), 58th Support Battalion of the Maryland Army National Guard explains its job to those attending last year's Maryland EMS Olympics. In the background is the portable "MASH" hospital.

Region I Offers Course On Trauma/Disasters

The "Western Maryland Trauma and Disaster Short Course" is scheduled for May 5 and 6 at the Grantsville Holiday Inn. The two-day program will cover topics ranging from prehospital diagnosis and treatment of abdominal trauma to pediatric emergencies, as well as practical workshops on "patient packaging" techniques for emergencies in a cold weather/rough country environment.

Physicians from MIEMSS Shock Trauma Center, Raymond M. Curtis Hand Center in Baltimore, Georgetown University's Center for Sight, and George Washington University School of Medicine—Pediatric Trauma Unit will serve as faculty for workshops on topics relating to their specialty referral centers. Garry Briese, executive director of Florida ACEP, will also address the workshop.

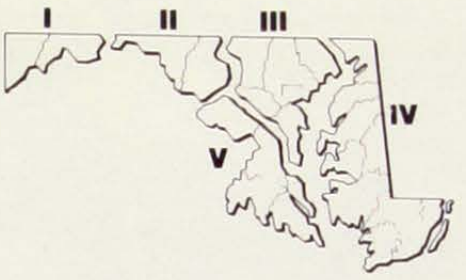
The workshop is a joint effort of the Region I offices of the Maryland Fire and Rescue Institute and MIEMSS and of the Continuing Education Divison of Garrett Community College.

The program is open to emergency care providers across the state. For information, call the MIEMSS Region I Office, (301) 895-5934.

Workshop Schedule

DATE	WORKSHOP	LOCATION
Apr. 4	**Traumatized Adolescent** — Normal adolescent development review and the impact of trauma on it.	Bon Secours Spiritual Center, Marriottsville
Apr. 5	**Pediatric Infectious Disease** — Focuses on Reye's Syndrome, pneumonia, sepsis in the newborn, and meningitis.	University of MD at Baltimore, M.S.T.F., Auditorium
Apr. 10	**Infection Control in the Critically Ill** — Includes I.V. fluids and lines, P.A. catheters, arterial lines, cardiac output, hyperalimentation, intraventricular monitoring, bladder catheterization, peritoneal lavage, hemodialysis, and respiratory equipment. Limit: 50 participants.	Leland Memorial Hospital, MIEMSS
Apr. 17	**Rehabilitation Nursing in Acute Care** — Focuses on rehabilitation techniques and philosophies that can be easily incorporated into the acute care setting.	Montebello Center
Apr. 17, 18	**Pediatric Emergencies** — Discusses pediatric assessment, pediatric CPR, SIDS, poisonings, burns, and the treatment of fever.	Peninsula General Hospital, Educational Center Building Auditorium, 1st Floor
Apr. 27	**The Practitioner's Guide to Emergency Psychiatry** — Reviews the practical approach to managing patients with psychiatric emergencies [clinical, legal, and administrative issues]. For law officers, all levels of ambulance personnel, and ED health care providers. Sponsored by the Mental Hygiene Administration, DHMH and MIEMSS.	Chestertown

Preregistration is required. Advance mail-in registration is requested seven days prior to the program date. For further information, contact the field nursing department at (301) 528-3930, or call your regional administrator.



Regional Offices

REGION I (Garrett, Allegany counties)
David Ramsey, Ravene Street, P. O. Box 34, Grantsville, Maryland 21536, (301) 895-5934.

REGION II (Frederick, Washington counties)
Michael S. Smith, 1610 Oak Hill Avenue, Hagerstown, Maryland 21740, (301) 791-2366.

REGION III (Metropolitan Baltimore)
George Pelletier, Jr., MIEMSS, 22 S. Greene Street, Baltimore, Maryland 21201, (301) 528-3997.

REGION IV (Eastern Shore)
Marc Bramble, John Barto, 331 North Aurora Street, Easton, Maryland 21601, (301) 822-1799.

REGION V (Metropolitan Washington)
Marie Warner, Ed Lucey, Landover Mall, West Office Building, Suite 202, 2100 Brightseat Road, Landover, Maryland 20785, (301) 773-7970.

Colts Reunion Benefits MIEMSS

(Left to right) Alasdair Conn, MD, deputy clinical director of MIEMSS Shock Trauma Center and medical officer for field operations, John Unitas, Jim Mutcheller, and Steve Myhra recently toured the Shock Trauma Center and discussed plans for the Colts reunion celebration that benefitted MIEMSS. The event was held December 28 to commemorate the silver anniversary date of the 1958 NFL world championship game. At the benefit celebration, key players shared remembrances of the title match; the game was shown; and a reception and autograph session followed for the fans. John Unitas was honorary chairman of the event which raised approximately $4000 for capital equipment for the new Shock Trauma Center building. Prior to the reunion celebration, Surgical Specialties, Inc., held a VIP dinner at the Marriott Hunt Valley that was attended by Colts players and guests.

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At the Center for Living

An orientation for prospective clients and interested EMS providers will be held April 13, from 1 to 3 pm at the Center for Living, 3700 Fourth Street, in Brooklyn.

The Center for Living is a postrehabilitation therapy center where former trauma patients and their families can obtain continued help in readjusting their lives following long-term acute and rehabilitation hospitalization.

The orientation consists of a videotape on the Center for Living and the different programs offered, a more in-depth presentation on cognitive relearning — its newest program, and a tour of the facilities.

For more information and for reservations, call Bonnie Hulson at the Center for Living, (301) 355-0100.

Instructors Training Set

A 40-hour instructors training course will be offered March 12–16 in Easton and June 18–22 in Hagerstown. The course meets the MICRB training standards. For further information, contact Ron Schaefer at MIEMSS (301) 528-3666.

Coalition for Rehab

Twelve representatives from MIEMSS clinical programs are currently serving as subcommittee members for the Coalition for Rehabilitation established by the Governor's Office for the Coordination of Services to the Handicapped.

The goal of the coalition is to effect a coordinated and comprehensive approach to rehabilitation; to recommend rehabilitation policies to governmental agencies, regulatory bodies, and elected/appointed officials; and to educate the public on existing services, and increase awareness of the ongoing rehabilitation needs in Maryland.

Let's Hear from You

Let us hear from you about what you or other EMS providers are doing that's new or unusual. Also, please send us any tips on patient management techniques or on equipment that you'd like to share with other EMS providers. Send your ideas to the "Maryland EMS News," Publications Office, MIEMSS, 22 S. Greene St., Baltimore, MD 21201.

Trauma/CC Nursing

Applicants for the fall 1984 specialty track in trauma/critical care nursing are currently being accepted by the University of Maryland School of Nursing. This three-semester master's program incorporates theoretical classroom study and clinical practice. MIEMSS Shock Trauma Center and the designated regional trauma centers in Maryland serve as the clinical practice sites.

For information, contact Patti Hurn, RN, MS, CCRN, Trauma/Critical Care Faculty, (301) 528-3890.

Para-Scope '84 Slated

Para-Scope '84, sponsored by the Emergency Medical Services and the Fire and Rescue Services of Montgomery County, is scheduled for August 24–26 at the Bethesda Marriott Hotel.

The program, consisting of lectures and workshops on various emergency care topics, is open to paramedics and paramedic instructors.

For information, contact Captain Mary Beth Michos, RN, (301) 251-2114.