MIEM DEMS MERGE, FORMING MIEMS

Effective July 1, 1977, the Division of Emergency Medical Services (DEMS), the coordinator of the statewide EMS system, and the Maryland Institute for Emergency Medicine (MIEM), the clinical core of Maryland's EMS system, will be combined into the Maryland Institute for Emergency Medical Services.

This amalgamation will provide for the continuation of the activities and functions of both DEMS and MIEM under a central unified management. The new Maryland Institute for Emergency Medical Services (MIEMS) will be part of the University of Maryland at Baltimore. DEMS is now under the Maryland Department of Health and Mental Hygiene; MIEM is part of the University of Maryland Hospital. Both will be transferred to the University of Maryland at Baltimore to become part of the new MIEMS. In the past, DEMS and MIEM have always worked closely with each other to improve patient emergency care and develop the essential supporting systems of communication, transportation, education, and coordination.

R Adams Cowley, M.D., Director of DEMS and MIEM, will assume the directorship of the combined MIEMS. Appointed by the Board of Regents of the University of Maryland, Dr. Cowley will be responsible to the chancellor of the University of Maryland at Baltimore.

The amalgamation of DEMS and MIEM is the result of state legislative action passing Senate Bill 852. This bill was introduced by Senator Roy Staten (D., 8th). The bill, with amendments, was approved by the Senate and the House and signed into law April 29 by Lt. Governor Blair Lee.

John Stafford, M.D., DEMS Director for Professional Services, and Norman Tarr, M.D., MIEM Medical Administrator, witnessed the signing ceremony and were presented the pens used to sign the bill.

The main focus in furthering Maryland's EMS system will be the development of advanced life-support systems, requiring physician and hospital input. This advanced training will benefit from the clinical components and EMS-systems professionals of the new MIEMS.

There are several advantages offered by affiliating MIEMS with the University of Maryland. The professional schools of Medicine and Nursing will provide an appropriate environment for advanced life-support training and other educational programs. The organizational change will make possible closer cooperation with the University's Fire and Rescue Institute which is responsible for basic life support training and with the University College for continuing and adult education courses. The University aegis will give legitimacy and credibility to accrediting MIEMS instructional programs. Additional grants for EMS development should also be more available when the DEMS programs are within the University.

The relationship of citizens, providers, hospitals, and communities in Maryland to the combined organization will not change substantially, except that it should be easier to deal with the unified management.

BALTIMORE REGIONAL BURN CENTER COMPLETES RENOVATION

"Death and survival are not the critical issues in burn care. Both of these are related to burn size and the age of the victim, and there is relatively little that can be done to dramatically change these conditions. But we can improve the result of burn care in those that survive."

As Andrew M. Munster, M.D., Director of the newly expanded Baltimore Regional Burn Center at City Hospital, continues to speak about burn care, he explains the team approach to the severely burned patient. This team approach is concerned not only with medical management but with facilitating the patient's return to normalcy in all areas of life. It is in this team approach that the Burn Center—a specialty referral center in the State's EMS system—differs from community hospitals. Although many community hospitals offer burn treatment, they do not provide their own staff of supportive services dedicated to the specialized care of the burn patient.

The "burn team" at Baltimore's Burn Center consists of doctors, nurses, physical and occupational therapists, psychologists, psychiatrists, teachers, medical social workers, rehabilitation guidance counselors, and clergy. Team members contribute to the total

EMS NEWS
JUNE 1977 VOL.4 NO.4
STATE OF MARYLAND - EMERGENCY MEDICAL SERVICES

care of the patient on a regular day-to-day basis.

Because the skin is the body's largest organ, major burns are considered the worst injury and form of trauma that a patient can sustain. Many body systems are disrupted, and a severely burned patient needs constant specialized care for several months, as well as rehabilitative help for many additional months. Infection, the most serious threat to the burn victim, must be prevented; bodily movement restored; and frequently many skin graft operations performed. During the long healing process, the patient has to cope not only with physical problems but with emotional and psychological problems. There are fears of disfiguration, scarring, and disability.

During the first 48 hours following a patient's admission, each member of the burn team meets briefly with the patient. These initial meetings are followed by many other sessions; in addition, the entire burn team goes on patient rounds and provides updates on patients' progress (for example, progress with splinting, acquiring new employable skills, etc.). This assures that when the patient is medically fit to return home, he or she will also be emotionally, economically, and socially prepared to return to community life.

The emphasis on team care is also extended to the patient's family. Dr. Munster, who has published widely on burn trauma, notes that "it's almost impossible to describe what a severe burn does to the family. It turns it upside down for years. I see part of our job here as keeping the family supportive during the time of stress." For the burn team, treating the patient is only part of their work; the family is also counseled to enable them to cope with their own fears for the patient and for themselves and to enable them to be more supportive of the patient.

Greater stress on the team approach and new techniques of care in burn medicine have given the Burn Center an inner "face-lifting" that complements its outer renovation. More than $250,000 was spent for new equipment and expanded and renovated facilities to provide additional specialized care for more burn patients. (Part of the equipment costs—$179,100—was funded through DEMS' federal funds.)

Dr. Andrew M. Munster (Photo: Courtesy of Baltimore City Hospital)

The renovated and expanded Baltimore Regional Burn Center is housed on the sixth floor of the "A" Building at City Hospital. There are less than 20 such burn centers in the nation. The only burn center in Maryland and the largest center between Philadelphia and Richmond, the Burn Center receives patients with major burns from Maryland and neighboring Washington D.C., Pennsylvania, Delaware, and West Virginia. (Occasionally, the Burn Center also receives patients from as far away as Bermuda.)

Operative since November 3, 1976, the expanded Burn Center has doubled its patient capacity. Last year approximately 100 seriously burned patients were treated; the Burn Center can now care for 200-250 patients annually. In the acute care area, there are currently ten beds for adults and five beds for pediatric patients, cared for by a staff of 40.

Dr. Munster is looking forward to increasing the nursing staff in order to open 15 beds for subacute care. This subacute care area would serve patients needing less intensive care, such as those undergoing plastic surgery.

Seriously burned victims are taken either by Maryland State Police Medevac chopper or by ambulance to the Burn Center. Patients treated include those with burns larger than 30 percent body surface on adults; burns larger than 20 percent body surface on children; burns of less percentage that involve crucial areas such as the face and hands; and special burns such as electrical and chemical burns. Transportation and admission policies are formed in cooperation with DEMS.

In addition to providing special patient care, the Baltimore Regional Burn Center also has teaching and research components. The Burn Center is a teaching affiliate of Johns Hopkins Hospital. Many staff members are from Hopkins, including the chief resident in plastic surgery, burn fellows, first-year residents, and interns; each month there is also a rotating affiliate resident from a hospital other than

Burn patient is lowered into hydrotherapy tub. (Photo: Courtesy of Baltimore City Hospital)

Hopkins. Dr. Munster, Director of the Burn Center, was a surgeon at the Medical University of South Carolina before coming to Balti-

more last August, and is also an associate professor of surgery at the Johns Hopkins Medical Institutions.

The Burn Center has its own research lab for environmental surveillance where millions of human cells - the cells of burn victims - are studied. Among the activities conducted is the quantitative culturing of burn wounds for the study of infection and host resistance. New topical creams and antibiotics are also being investigated.

The broad commitment of the Burn Center to improving burn care is also reflected in its contribution to community service. In addition to treating victims of major burns, the Center accepts patients with minor burns as outpatients. A Burn Clinic is held every Tuesday to provide follow-up treatment for burn victims. Further community service is provided by staff members participating in DEMS–sponsored workshops for nurses and emergency medical technicians. A newly hired physician's assistant is also contributing to patient care at City Hospital's Emergency Department and hopes to work with EMT groups throughout the state.

Although renovation is completed, innovation is continuing at the Burn Unit. Through an interdisciplinary team approach, the Baltimore Regional Burn Center is working to give new dimensions to burn medicine in the areas of specialized patient care, teaching, research, and community service.

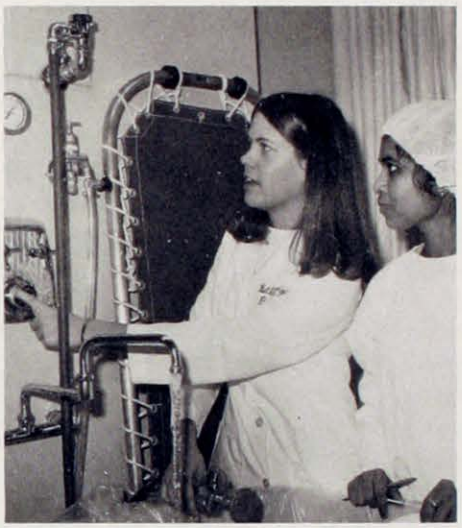
A MINI-TOUR OF THE BURN CENTER

If you have never toured the Baltimore Regional Burn Center, Beth Helvig, Nurse Clinician at the Center, will start you in the Hydrotherapy or Tub Room, the admitting area and "core" of the Center. Responsible for providing a two-week orientation for every new nurse at the Burn Center and for educational development workshops for staff nurses, Beth also frequently teaches patients and their families. As she begins a description of the main steps in the examination and assessment of a burn patient, you conjure up an imaginary patient and visualize the scene—from the preparation of the tub and litter for the patient to the gentle cutting away of his clothes, placing him on a litter and lowering him by a lift into the warm whirlpool bath where his wounds will be bathed.

Beth also explains the problems of infection, fluid loss, swelling, and loss of mobility faced by burn patients and the need for such equipment as ceiling heat shields, whirlpool baths, Foley catheters, IV tubes, respirators, and breathing tubes to help the patient withstand the stress of the burn injury. She points out how each patient is "tubbed" frequently to remove dead skin and cleanse the wound and how each isolation room has its own equipment (for example, stethoscope, respirator, oxygen, blood pressure, suctioning equipment), monitors, sink, bed, etc., to avoid cross-contamination. As you enter a patient's room (vacant now), you might be preoccupied with the equipment and with the challenge of burn management. Perhaps because of this preoccupation, your eyes are drawn to the window. It might not seem like much, but it is a touch of the "real" or "outside" world.

That window or link with the outside world somehow seems symbolic of the atmosphere at the Burn Center. Here the staff is trying to help patients realize that they are not "alone" but have the support of family and friends waiting for their return and the encouragement of other burn victims who are now leading productive lives. Family and friends, as well as former patients who are now part of the Burn Victims Aid Society, are considered an active part of the burn team in hastening the patient toward recovery and resuming a normal life.

Special care is also given to fostering a positive mental attitude among patients. For example, staff and visitors entering the acute care wing were previously required to scrub and to wear surgical gowns and caps--and frequently masks and gloves. Beth notes, however, that seeing everyone so attired often had a distressing psychological effect on patients who associated the surgical garb with "very critical" and "little hope of recovery." The Burn Center now has four levels of isolation rooms based on the patient's condition—each requiring a different protocol (from "surgical gown and cap not required" to "surgical gown and cap required and disposed of before leaving the patient's room").



Beth Helvig demonstrates the regulation of water temperature for hydrotherapy tub. (Photo: Courtesy of Baltimore City Hospital)

Because a burn patient fighting infection uses two to three times the normal amount of calories needed, patients are given several small meals and encouraged to snack frequently—thus the refrigerator stocked with sandwiches, milkshakes, juices, ice-cream, and high-protein foods.

Therapists work daily with patients to avoid having their joints stiffen. Foot splints, individual finger splints, extension splints for elbows and knees and even neck and nose splints may be made for patients to keep these parts of the

(continued on p. 7)

RESCUE: WATER-RELATED ACCIDENTS

National statistics indicate that water-related accidents are the third leading cause of accidental deaths. With 4433 miles of tidewater shore — including freshwater lakes and rivers — and with an increase in water and boating activities, Maryland also has a high rate of water-related accidents. The ingenuity of Emergency Medical Technicians (EMT's) is an asset in rescuing drowning victims and reversing the drowning process.

Emergency Care

In freshwater drownings, water entering the lungs is assimilated into the blood stream, upsetting the electrolyte balance and thereby causing heart irregularities. The reverse occurs in saltwater drownings. The body fluids of a victim drowning in salt water are drawn into the lungs, upsetting the electrolyte balance and causing pulmonary problems that lead to death. EMT's should not waste time trying to remove water from the victim's lungs. Most studies indicate that only small volumes of water enter the lungs due to the fact that a patient choking on large amounts of water usually goes into laryngospasms and asphyxiates.

Therefore, the first step of the EMT should be to begin artificial ventilation immediately. Mouth-to-mouth resuscitation can be performed satisfactorily in the water (artificial resuscitation is more effective, however, when performed out of the water). The victim must be removed immediately to a firm surface if cardio-pulmonary resuscitation is to be performed effectively.

Victims with suspected spinal injuries should be handled with extreme caution to prevent further injury. Cervical collars and backboards should be utilized before the patient is transferred from the water. (Any firm surface such as surfboards, doors, chaise lounges could be used to immobilize the victim.) It should be noted that a patient wearing a standard life jacket cannot be effectively immobilized, for the flotation device prevents proper alignment of the cervical spine. (See below for new types of jacket flotation devices.)

Positive pressure oxygen should be utilized as soon as it is available. Pulmonary problems and electrolyte imbalances may develop several hours after the drowning. Constant monitoring of the patient and follow-up medical care in a hospital are a *necessity* to prevent further complications.

Placing a victim in a Stokes basket having flotation devices attached

Water-Rescue Equipment

Standard ambulance equipment generally cannot be used effectively in water-related accidents; however, it can be *adapted* to handle water rescues. The following methods of water rescue are presented as alternatives to methods now being utilized. They have been proven effective by the rescue crews of *Star of Life I* and *II*, two sea ambulances.

In attempting to rescue drowning victims, EMT's should remember to protect themselves with lifelines and flotation devices to avoid becoming victims themselves through over-exertion. The safety of both rescuer and victim are prime concerns.

Wooden Backboards

A Styrofoam wedge measuring 8 inches at the head and tapering to 2 inches at the bottom (to provide for maximum flotation at the head) should be attached to the bottom of a wooden backboard. This will provide for the flotation of the unconscious victim and will maintain the victim's head and shoulders above the water level.

Stokes Baskets

There are two basic types of Stokes baskets: fiberglass and metal-frame/wire-mesh. Neither type will float a victim unless flotation devices are attached. Boat bumpers, plastic milk containers, or life jackets--attached at the head of the stretcher and in the area of the victim's elbows--can be utilized as flotation devices to facilitate han-

dling and transport of the victim. To place the victim in the basket the rescuer should remove the flotation device on the side closest to the victim, submerge the basket under the victim, and then reattach the flotation device to the side of the basket when the victim is positioned. It has been demonstrated that three life jackets used as flotation devices attached to the basket will support an adult male, maintaining his head and shoulders above the water level. It should be remembered that the fiberglass basket will retain water, adding extra weight to the basket when the victim and basket are lifted out of the water; however, water easily drains out of the wire-mesh type as the victim and basket are removed from the water.

Extended Reach Rescue and Flotation Devices

There are several alternatives to the standard life buoy.

Weighted Rope. A rope can be tied to a buoyant object such as a closed milk jug that is one-quarter to one-third filled with water and tossed to the victim who can then grasp it for flotation.

Utilizing cervical collar and backboard in water rescue (note Styrofoam wedge attached to backboard)

Section of Inflated Fire Hose. An inexpensive and amazingly effective rescue device can be fabricated from a 50-foot section of fire hose. The rescuer should cap the extended end and adapt the cap at the other end for inflation. (Compressed air supplies such as Scott bottles are readily available to most rescue companies and can be used for inflation. The hose cap can be easily adapted for inflation at a local machine shop.) The hose can be inflated by throwing it overboard and inducing air through the adapted cap. As the hose fills with air, it will straighten and float on the water. After it is inflated, the hose can be used to effectively support several victims. In both water and ice situations, it can be used as a "bridge" or "arm" to lead either the rescuer to the victim or the victim to safety. After sealing both hose ends and removing the air supply, swimmers can also take the inflated hose into areas inaccessible to or unsafe for boats. Extra hose sections can be added to increase the reach of the hose.

Life Jackets. Most life jackets have a large amount of bulk located in the area of the back or neck. This prevents the patient from being properly immobilized on a backboard. However, there are new types of flotation devices, such as the water-skier's vest, that are not excessively bulky and allow for the effective immobilization of a patient on a hard surface.

Splints

Air splints are difficult to inflate while the rescuer supports himself and the patient in the water. A new type of splint made of rigid plastic with Velcro fasteners will float and can be applied while the patient is in the water. Standard wooden splints will float, but the application of cravats, Kerlex, and tape is severely hindered in water rescues. It is important for the rescuer to remember that any equipment used in the water (for example, scissors, airways, etc.) should have flotation. This can be assured by attaching such items to a sealed can with a string.

Editor's Note: Comments on these water-rescue methods and ideas for alternative methods are welcome and should be submitted to Lou Jordan, DEMS Paramedical Training Specialist.

Inflating air splint (note splint with Velcro fasteners on right)

PROFILE
PEGGY TRIMBLE

The 5-floor, 33,142 square-foot Maryland Institute for Emergency Medicine (the State's specialty referral center for adult trauma) was only a skeleton of steel girders next to University of Maryland Hospital's south building. That was ten years ago. And that was when one of Peggy Trimble's patients took a turn for the worse. "All of a sudden he was transferred to the Trauma Unit," then a two-bed room on the University of Maryland Hospital's fourth floor, "and the doors closed behind him. They wouldn't let me go in and I wanted to know what was going on. That was when I decided to find out about trauma." Peggy's infectious laughter animates her recall of events.

But there were also other reasons for the interest in trauma that would eventually immerse Peggy's career as a nurse and teacher.

Trauma was a new field. "I thought of the trauma unit as a place where there would always be new horizons, new doors to open. The Shock Trauma Unit had an active research program; a 1:1 nurse-patient ratio; and the Unit seemed to be a step ahead of other patient care areas."

Peggy Trimble, RN, BSN, is now the DEMS Nurse Coordinator of the burns, pediatric, and neonate workshops. Except for a year and a half at University of Maryland Hospital's Open Heart Recovery Unit and Veterans Administration Hospital, Peggy has worked in various areas of trauma care at the Maryland Institute for Emergency Medicine (MIEM), both in the old two-bed trauma unit and then in the larger complex opened in May 1969.

Her first two years as a clinical nurse and then as head nurse/team leader at MIEM were spent with patients in the emergency resuscitation, admission, and intensive care

areas. During this time she also developed an expertise in pediatric trauma and hyperbaric therapy. (She remembers stopping traffic and wheeling patients across busy Greene Street from the hospital to the hyperbaric chamber then located in the Bressler Building.)

For the next few years at MIEM Peggy turned to teaching. "I believe that one way to effect change is through education....It's much easier to take a nurse and teach her the right way to do something than to try to retrain her."

During this time, Peggy also taught critical care nursing, as well as the first MIEM continuing education program for nurse clinicians. In addition, she started sessions in paramedic skills training for helicopter paramedics.

Peggy began taking her teaching skills beyond the MIEM doors when she became coordinator of the DEMS continuing education program for emergency and critical care nurses in June 1975. Last year Peggy presented burn and pediatric trauma workshops throughout the State. This year she repeated them and also introduced a workshop on neonate care.

She sees the workshops as not only offering nurses and emergency medicine personnel a chance to update theory and skills but as offering an opportunity for interpersonal involvement between referral centers and local communities in discussing problems of patient care and working toward realistic solutions. To accomplish this, Peggy involves experts from the specialty referral centers in her workshops and is also interested in including experts from local community hospitals in workshops offered in their regions.

Most workshops average 40 participants although the first neonate workshop drew 78 nurses "which demonstrates a real need in this area." The majority of the workshop participants have been emergency department and intensive care nurses. But more industrial, school, and public health nurses, as well as nurse practitioners, are beginning to attend. "People are beginning to realize that emergency medicine doesn't happen only in the emergency department. It really has a broad community-based impact." In fact, Peggy believes that parts of workshops, such as the pediatrics workshop, could be modified and presented as public education workshops.

Peggy also teaches orthopedic assessment in the trauma workshop and is writing a chapter on "Injuries to Bones, Joints, and Associated Soft Tissues" for *Trauma Nursing*, a book by Liz Scanlan (Director of Nursing for MIEM and DEMS) and MIEM and DEMS staff.

In addition to coordinating DEMS nursing workshops, Peggy often lectures at out-of-state workshops. She was also part of an eight-person critique panel that worked on trauma course curriculum content for teaching modules developed by the American Association for Critical Care Nurses. In the past year, she has traveled to Maine, Virginia, New Jersey, Seattle, and the Virgin Islands.

A sensitivity to people, especially to patients, seems to surface unconsciously in Peggy's conversation. It is that concern for patients that propelled her to open that first door in the Trauma Unit. She has since opened a lot of other new doors—and is now opening them for a lot of other nurses.

(continued from p. 3)

body in a normal position and prevent contractions. In the lounge, you can find products made by patients--wall hangings, trivets, and other objects.

Since third-degree burns do not heal by themselves, skin-graft operations--with skin taken from an unburned area of the victim--must usually be performed several times. Small patches of skin are usually stretched to three times their normal size on a special machine at the Center before they are placed over the burned area and sutured in place. Grafting, however, sometimes causes fears about one's appearance. For example, Beth recalls that one patient had third-degree burns completely covering his face. Although only three grafts were necessary, and there was little scarring, the patient did not look like his "old self" and many friends did not recognize him.

After a patient is dismissed from the Burn Center, he usually reports to the Burn Clinic on a regular basis to discuss medical problems and "adjustments" to the rehabilitative phase. Even when there is no disability, severe burns usually put limitations on a patient's normal daily routine. For example, scar tissue tends to swell if there is no pressure to keep it flat; patients sometimes have to wear Jobst garments (specially made to fit the burned part of the victim's body and to keep scars flat) for as long as a year. Splints, too, must often be worn at home. Other problems include an extreme sensitivity to sun causing severe blistering of the burned part. To prevent contractions, patients also have to maintain a strict exercise routine.

Patients spend months in the acute-care and rehabilitative stages of their recovery. During that long wait to recovery, there is pain and stress--and fear. The Burn Center staff cannot erase the waiting, but they are working to erase the fear and replace it with realistic hope for a productive life.

Distinguished Marylander Award

On behalf of the Advertising Club of Baltimore, the Hon. Louis L. Goldstein, Maryland Comptroller, presents the Distinguished Marylander Award for 1977 to R Adams Cowley, M.D. Dr. Cowley was recently honored by the Advertising Club at a luncheon attended by more than 600 guests.

LOCAL FIREFIGHTERS RAISE FUNDS FOR BURN RESEARCH

Although the Baltimore Regional Burn Center has recently completed a major renovation of its facilities to improve burn care offered to patients in the surrounding four-state area, there is a shortage of funds for burn research to further improve treatment.

According to Andrew M. Munster, M.D., Director of the Burn Center, the lack of funds available for burn research is due partly to the fact that the importance of the burn problem has not yet been fully realized. "Consider that 2 million people in the United States are burned; about 100,000 get hospitalized; 20,000 die." More numbers are claimed by cancer and heart disease, but "the burn problem outweighs its numbers considerably. Many burn victims are children and many are men and women in their productive years." Of the 6,000 or so hospitals in the United States, however, only 90 have special services for burns and less than 20 qualify as burn centers.

The "burn problem" is further compounded by the neglect of the federal government to appropriate enough funds for research. "Compare the $3.40 per patient for cancer research to the one cent per patient for burn research."

In an effort to remedy this situation, the Baltimore City Firefighters (Locals 734 and 964) are conducting fundraising events on a continuing basis to benefit the research unit at the Burn Center.

Working toward their goal of raising $50,000 - $100,000 during a one-year period, they have scheduled events such as bull roasts, dances, and a golf tournament. On June 21, they plan to present the first check to Dr. Munster.

Charlie Williams (Local 734) and Gustave Calo (Local 964) are chairmen of the fundraising efforts.

STATE OF MARYLAND
DIVISION OF
EMERGENCY MEDICAL SERVICES

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DEMS REQUESTS HEW 1204 FUNDS

The Division of Emergency Medical Services recently submitted to HEW a 1204 grant application for development of an Advanced Life Support System in EMS Regions I, II, and IV. At the same time a 1204 grant application for EMS Region V was submitted by the Council of Governments for the Metropolitan Washington D.C. area.

The major emphasis in the 1204 grant proposal is a provision for physician leadership and direction in each of the three regions. Provision has been made to establish a physician group consisting of a project director and a physician clinical director for each of the major clinical areas in each of the three regions. These groups would be responsible for working with the Division of Emergency Medical Services to further develop triage and treatment protocols for their regions; assist in gathering evaluation data; and provide regional physician direction.

Also included in the grant request are funds for physician and paramedic training as well as funds to expand CPR training for the general public.

Information received to date indicates that HEW received grant requests totaling $7,513,548 for the HEW Region III, which includes Maryland. This amount is approximately twice as much as the HEW representatives expect to be able to allocate.

Grant awards will be made at the end of June 1977. Bill Hathaway, DEMS Executive Assistant Director, feels that "with the assistance of the EMS Councils and the cooperation of the physicians in the Regions, we were able to prepare a sound and competitive grant request."

DEMS MEDIA MATERIAL AVAILABLE

Films and slide/tape programs can be borrowed from the Media Library of the DEMS Educational Services Branch. To obtain further information or to reserve a program, contact the DEMS regional coordinator in your area.

DEMS MIEM MERGE, FORMING MIEMS

Effective July 1, all correspondence to DEMS and MIEM should be addressed:

Maryland Institute for Emergency Medical Services, 22 South Greene Street, Baltimore, Maryland 21201

DIRECTORY OF EMS COORDINATORS

Maryland EMS Regional Coordinators are located throughout the State to respond to the needs of emergency medical personnel, citizens, and various community groups in their regions. The regional coordinators can be reached as follows:

Region I - Appalachia Region (Allegany and Garrett Counties)

David Ramsey - Ravene St., P.O. Box 34, Grantsville, Maryland 21536, 895-5934.

Region II - Mid-Maryland (Frederick and Washington Counties)

Michael S. Smith - 1610 Oak Hill Ave., Room 134, Hagerstown, Maryland 21740, 791-2366.

Region III - Metropolitan Baltimore (Baltimore City and Baltimore, Anne Arundel, Harford, Howard, and Carroll Counties)

George Pelletier, Jr. - Equitable Trust Building - Suite LL-7, 401 Washington Ave., Towson, Maryland 21204, 828-5300.

Region IV - Eastern Shore (Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Somerset, Wicomico, and Worcester Counties)

Marcus Bramble; Marie Warner (Assoc.) - 12 N. Washington St., P.O. Box 536, Easton, Maryland 21601, 822-1799.

Region V - Metropolitan Washington (Montgomery, Prince George's, Charles, Calvert, and St. Mary's Counties)

Jeff Mitchell; Ed Lucey (Assoc.) - 5408 Silver Hill Rd., Suitland, Maryland 20028, 735-5580.

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