



NEWS

DECEMBER 2011

Vol. 20 NEWSLETTER OF THE NATIONAL ASSOCIATION OF EMS PHYSICIANS®

No. 3

President's Corner

Ronald G. Pirrallo, MD, MHSA
NAEMSP® President, 2009-2011



Founding Fathers

Last week, I stood on our nation's Mall reading the names of the 56 signers of the Declaration of Independence. It caused me to smile as I just penned my first letter to the editor to the *Milwaukee Journal Sentinel*. Budgetary pressures are threatening to dismantle our EMS systems. Like our founding fathers, I am hopeful the written word has the power to change the future.

My letter was an attempt to educate decision makers on the essential EMS system components. As Medical Director for the Milwaukee County EMS System, I see one of my most important roles is to lead through the sharing of knowledge. NAEMSP® also embraces this role. Whether it is at EMS on the Hill day, the Asian Conference of Emergency Medicine, EMS Today or the NAEMSP®'s Medical Direction Overview Course™ in Evansville, Indiana, NAEMSP® members are educating leaders on EMS issues. Along these efforts, I am pleased to report that Representatives Tim Walz (D-MN) and Sue Myrick (R-NC) have introduced H.R. 3144, the **Field EMS Quality, Innovation, and Cost-Effectiveness Improvements Act of 2011**.

'Field EMS' may seem like an odd term to describe what we do every day but it has been effective in differentiating our unique practice of medicine when educating decision makers.

'NAEMSP® also embraces this role.'

NAEMSP® members have been active at all levels in shaping our nation's dialogue on the future of EMS. This future includes the

first ABEM Subspecialty Examination in EMS planned for 2013. It is estimated that more than 1,000 physicians are expected to take this inaugural examination. It is with great excitement that the NAEMSP® Board of Directors has selected Dr. Charles Stewart as the Program Manager for the development of the NAEMSP®/ACEP Subspecialty EMS Board Examination Online Review Course. Dr. Stewart is Professor of Emergency Medicine and Director, Oklahoma Disaster Institute in the Department of Emergency Medicine at the University Of Oklahoma School Of Community Medicine. He is a long-time NAEMSP® member mentored by Drs. Peter Safar and Don Benson well before our organization was even born. He has great insight on media learning and building EMS educational products. When asked to describe his project management style he replied without hesitation *"on time and under budget."* The review course is expected to be completed next winter in ample time to study for the new boards.

The NAEMSP® Board of Directors understands the importance of our organization's core value and strategic foci of education. I strongly encourage you to attend the January Annual Meeting in Tucson. See for yourself the excellent meeting the Program Committee has assembled. I applaud all of our members who embrace the role of educator and work hard to improve EMS. It is an effort that I hope will have its own worthy legacy. *



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2012 ANNUAL MEETING

David E. Slattery, MD
Program Chair

As I sit here writing this on Thanksgiving Eve, I realize we will soon be flying through the holiday season and emerging into the new 2012 year. With the New Year comes the anticipation of the NAEMSP® Annual Meeting. For all of you who have attended in the past, you are well aware that this meeting is so much more than just a place to “get my CMEs.” We know that although the educational and research content is outstanding, there exists an equal amount of magic outside of the meeting halls. As we attend the research poster sessions, chat over coffee with new and old friends, as we see the exciting new equipment and products in the exhibit hall, and of course as we reconnect with friends and colleagues from around the world, the true magic of the NAEMSP® meeting becomes palpable. I’d like to take a few moments and provide a glimpse of some of the magic we have planned in the upcoming conference at the beautiful JW Marriott Starr Pass Resort & Spa in Tucson, Arizona, from January 12-14, 2012.

First and foremost, I want to recognize the members of the Program Committee and our excellent NAEMSP® staff who have worked very hard to bring YOUR ideas to fruition at the January meeting. Although you may think that CME evaluation form you do every year never gets read, I’m here to tell you that our Program Committee and the Board of Directors take your comments and suggestions very seriously.

Based on our members’ suggestions, this year’s program has three major educational themes: Emergency Preparedness, Meeting the Challenges in EMS, and The Science of EMS.

EMERGENCY PREPAREDNESS
Emergency Preparedness. Unfortunately, 2011 has been a record year for local, regional, and international disasters. Although it is impossible to do any of the responses justice in a single hour presentation, we will be bringing you the collective experiences of six individuals intimately involved with the Tragedy in Tucson, The Japan tsunami/radiation disasters, and the tornados that destroyed many communities in Alabama and in Joplin, Missouri. The speakers will be sharing lessons learned in each of these unique disasters that are applicable to your EMS system and community.

MEETING THE CHALLENGES IN EMS
Meeting the Challenges in EMS. There are numerous challenges that we encounter in our profession. **Subspecialty Board Certification.** One of the most pressing issues, which is both exciting and angst-producing, is the process of EMS subspecialty certification. We are very fortunate to have three incredible speakers (Dr. Jane Brice, Dr. Debra Perina, and Dr. Dave Cone) who are closely involved with the subspecialty board exam and process. These national experts will provide

our members with an overview of the current status of the subspecialty test development, the final EMS core content, and the anticipated timeline for this process. If you are interested in pursuing subspecialty recognition, you do not want to miss this NAEMSP® presentation! **Pediatric EMS** The number one request from our members was to provide more pediatrics/EMS talks. NAEMSP®’s Pediatric Committee chaired by Dr. Toni Gross worked tirelessly with our Program Committee to bring you this important pediatric content. The CDC’s new *Trauma Field Triage Guidelines* will be announced at this year’s meeting along with an expert panel that will provide perspective and guidance for implementing these in your community.

THE SCIENCE OF EMS
The Science of EMS continues to push our specialty forward, and this year, above and beyond our usual oral research and poster sessions, we have several important and impactful research lectures. Topics such as Comparative Effectiveness Research, The Canadian Evidence-Based Medicine Project, and of course, the Top 10 Articles are just a few of the important research-related topics being presented at the 2012 meeting.

In closing, there are too many great talks to adequately cover here, but the entire Program Committee hopes you will find this year’s conference a stimulating, inspiring, and meaningful educational experience. You can find more information on the conference by clicking [here](#). We hope you will join us in the warmth of Tucson in January! *

The National Association of EMS Physicians® is an organization of physicians and other professionals partnering to provide leadership and foster excellence in out-of-hospital emergency medical services.

The NAEMSP® newsletter is designed to inform members of interesting developments in the field of EMS. Members are encouraged to send information which may be of interest to others reading this publication.

NAEMSP® News is the official newsletter of the National Association of EMS Physicians® (NAEMSP®).

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2011

Board of Directors Election Results

We are pleased to announce the newly elected NAEMSP® Board of Directors who will serve from January 2012 to January 2014.

Physician Members-at-Large Brent Myers
Allen Yee
Ronald Roth

Professional Member-at-Large Lynn White

Thank you to all of our members who took the time to vote for your Board of Directors.

Farewell to NAEMSP® Physician Members-at-Large **James V. Dunford, MD** and **Kathy Rinnert, MD, MPH**, as well as Professional Member-at-Large **David Hostler, PhD, EMT-P**. NAEMSP® wishes to thank these members for faithfully serving NAEMSP® on the Board of Directors.



Member-at-Large
Brent Myers



Member-at-Large
Allen Yee



Member-at-Large
Ronald Roth



Member-at-Large
Lynn White

Critical Care Medicine Certification

APPROVED FOR EMERGENCY PHYSICIANS

Frances M. Spring, Administrative Coordinator, Communications ABEM



American Board
of Internal Medicine®

Diplomates of the American Board of Emergency Medicine (ABEM) now have the ability to become board certified in Critical Care Medicine (CCM). The number of critically ill patients presenting to emergency departments is increasing nationwide. This opportunity is a natural extension of the practice of Emergency Medicine.

On September 21, 2011, at the General Assembly meeting of the American Board of Medical Specialties (ABMS), a joint program between the American Board of Internal Medicine (ABIM) and ABEM was unanimously approved. Emergency physicians can now supplement their Emergency Medicine residency training by participating in Internal Medicine – sponsored Critical Care Medicine (CCM) fellowships. Upon completion of CCM training, these individuals would be eligible to seek board certification.

By January 1, 2012, ABEM will announce the specific eligibility criteria, the timeline, and the administrative process for emergency physicians to access the critical care certification examination offered by ABIM. ABEM will issue the CCM certificate to its diplomates, but the certificate would indicate that the standards are the same as those of ABIM. Information about the program can be found at:

<http://www.abim.org/news/critical-care-medicine.aspx>

"We are excited that emergency physicians now have the opportunity to assess their knowledge and skills in critical care medicine and that a formal training pathway exists to build upon their emergency training, and that this will allow them the opportunity to become certified in this important subspecialty," stated Richard N. Nelson, M.D., ABEM President.

IM CCM becomes the seventh subspecialty available to ABEM-certified physicians along with Emergency Medical Services, Hospice and Palliative Medicine, Medical Toxicology, Pediatric Emergency Medicine, Sports Medicine, and Undersea and Hyperbaric Medicine. *

Standards and Clinical Practice Committee

Michael G. Millin, MD, MPH

The primary function of the NAEMSP® Standards and Clinical Practice (S&P) Committee is to develop the official positions of the association and its respective supporting documents, often referred to as resource papers. In general, there are two types of positions that the committee develops – positions that primarily support the practice of EMS medicine (e.g., Medical Direction for Operational EMS Programs) and positions that primarily focus on the clinical aspects of EMS medicine (e.g., The Use of Epinephrine for the Out-of-hospital Treatment of Anaphylaxis).

The S&P Committee is open to all NAEMSP® members and we highly encourage members to participate. The documents that are generated from the committee help to develop the future of EMS. In order to be representative of NAEMSP®, we need as many members as possible to contribute. Ideas for positions may come from within the committee, from other committees in the association or directly from the NAEMSP® Board of Directors. Small groups within the committee generally develop positions and the corresponding resource papers, which take the form of a literature review.

The committee's goal is to be as scientific as possible in the development of the positions and resource documents. Once developed, the documents go to the full committee for review and comment. After passing through the committee, the

documents go to the Board of Directors for review and further development or final passage as deemed appropriate. The positions and resource papers are posted on the NAEMSP® website and published in *Prehospital Emergency Care*.

The committee typically meets the first evening of the Annual Meeting. There is often a mid-year teleconference to catch up on developing projects.

If you are interested in joining the committee, come to the January meeting in Tucson at 5:00 pm on Wednesday, January 11, or email Committee Chair Michael Millin at MichaelGMillin@gmail.com. The S&P Committee would love to add your voice to its important work.

Some recent positions developed by the committee include:

- Ambulance Diversion and Emergency Department Off-Load Delay
- The Use of Epinephrine for the Out-of-Hospital Treatment of Anaphylaxis
- Termination of Resuscitation of Non-traumatic Cardiopulmonary Arrest
- EMS Provider Determination of Necessity for Transport
- Off-Label Use of Medical Products
- Non-invasive Positive Pressure (NIPPV) Ventilation *

NEW INNOVATIONS: Cardiopulmonary Plunger Resuscitation

Kamal Gursahani, MD

Over a decade ago, a man literally dropped dead in front of his teenage son. The son tried to do chest compressions, but did not feel he was doing them effectively so he grabbed a bathroom plunger. It was ingenious. His father regained circulation by the time the paramedics arrived, thus surviving a massive MI.

Impressed and intrigued by the plunger idea, doctors at UCSF who treated this man became interested in developing a device that would incorporate the “active compression-decompression” action of a bathroom plunger into a useful and portable CPR instrument. Shortly after its invention, the device's purported > 50% success rate at increasing survival was debunked by a study of more than 800 patients at UCSF and UC-Fresno in 2005. Some physicians reported that the device was difficult to use due to its design.

Flash forward to this year in which a group of researchers at the Medical College of Wisconsin performed an NIH funded study on “active compression-decompression” CPR vs standard CPR in which 53% more people survived using this device. The study also reports better neurologic outcomes and one-year survival. Interestingly enough, the French have been using a device like this for years.



Lancet. 2011 Jan 22;377(9762):301-11. Standard cardiopulmonary resuscitation versus active compression-decompression cardiopulmonary resuscitation with augmentation of negative intrathoracic pressure for out-of-hospital cardiac arrest: a randomised trial. *

Missouri Disaster Medical Team Response to Joplin Tornado

Helen Sandkuhl, Chief Nurse MoDMT

According to history, Joplin is no stranger to bad weather... but no one could have predicted what occurred in the late afternoon of Sunday, May 22. A devastating series of EF5 multiple vortex tornados struck the city with little warning.

Immediately following the disaster, the Missouri Disaster Medical Team (MoDMT) was deployed to assist with the multiple injuries. Missouri Governor Jay Nixon declared a “state of emergency” for the Joplin area shortly after the tornado hit and activated the Missouri National Guard. Missouri Task Force One was also deployed and began search and rescue functions.

MoDMT was on the ground and ready to care for patients within six hours of the incident. The whole team, including doctors, nurses, paramedics, logistics and communication specialists, was fully functional by the next morning to serve as a mobile emergency department.

During the next several days, the team treated a wide range of both pediatric and adult injuries and medical illnesses. Multiple elderly patients who were unable to obtain replacement medications for chronic medical conditions arrived at our facility. We helped to decompress the already overloaded health care system.

The tornado resulted in 162 deaths and more than 900 injuries. About 8,000 structures were destroyed and 18,000 vehicles were damaged; 450 businesses were leveled. These tornados would turn out to be the deadliest to hit the United States since 1947. It was the only EF5 tornado in Missouri history dating back to 1950. It would also turn out to be the seventh deadliest to date in the United States and the 27th deadliest in world history.

St. John’s Hospital, now called Mercy Hospital, in Joplin took a direct hit. The hospital census at the time of the tornado was 183 patients. Miraculously, all staff survived. Sadly, five patients and one visitor were killed.

The *Joplin Globe* reported that 54% of the people died in their residences, 32% in non-residential areas and 14% died in vehicles or outdoors. In addition, a Riverside, Missouri, police officer assisting in the response died on May 23 when lightning struck him.

The massive tornado that devastated Joplin touched down at 5:41 pm Central Time. It cut a path of destruction $\frac{3}{4}$ to a mile wide and nearly 7 miles long. The National Weather Service estimated the storm path at nearly 14 miles in length.

Freeman Hospital was inundated with critical patients. Bob Denton, the ED Nursing Director and MoDMT member, worked

alongside his staff caring for multiple injured patients. After the disaster occurred, Freeman Hospital staff had no idea that St. John’s Hospital was completely destroyed or realized the magnitude of the situation until patients from St. John’s Hospital started to arrive at its emergency department. Freeman Hospital also lost power, a portion of its roof and several windows.

It is now 5 months since that disaster, and I have just returned to Joplin. For first-time visitors to Joplin, the site may appear desolate and devastating. To EMS personnel who are returning, we see signs of teamwork, hope, faith and a strong community spirit. Our thoughts and prayers are with the people of Joplin. *

Bridging the Gaps

Vicki Mazzorana, MD

The Wilderness Medical Society (WMS) has collaborated with the NAEMSP® to offer a unique opportunity within the Desert Medicine Conference in Tucson, Arizona. It was held November 3-7, 2011.

As a concurrent track within the WMS Desert Medicine Conference, there was a Wilderness Emergency Medicine Systems (WEMS) Directors Meeting. This meeting was the first of its kind. It brought medical directors from across the nation together to further define the role of the medical director and educate directors on a vast array of topics and situational protocols.

Across the country, physicians are frequently asked to serve as medical directors of wilderness EMS systems. Such systems include ski patrols, backcountry rescue teams, wilderness education programs, summer camps, open water lifeguard rescue, technical rescue teams, traditional and tactical EMS teams with austere medical needs, and many other programs. Some physicians come into these roles with copious wilderness skills but little EMS experience or training. Others have strong EMS backgrounds but limited wilderness exposure.

The course prepared physicians for these roles and filled these training and experiential holes. Experts from both NAEMSP® and WMS developed the curriculum. *

Advocates for EMS:



The Field EMS Quality, Innovation and Cost-Effectiveness Improvement Act H.R. 3144 Introduced by Representatives Tim Walz (D-MN) and Sue Myrick (R-NC)

Abbreviated by Joseph A. DeLucia, DO, FACEP

Emergency Medical Services (EMS) Makes A Difference for Millions of Americans

Emergency medical services (EMS) encompass emergency medical care provided to patients at any point in the continuum of health care services. EMS provides services for a wide range of emergency medical conditions, from answering 9-1-1 calls, first response, field medical response, medical transport, hospital treatment and rehabilitation. EMS saves lives and is a unique and critical part of the healthcare delivery system. EMS is a public benefit provided by both governmental and nongovernmental providers that citizens assume will always be there to serve them. "Field EMS" refers to emergency medical and trauma care provided *outside* of the hospital, most often prior to and during transport to a hospital. Field EMS providers conduct nearly 25 million transports for more than 8% of the US population per year. "Hospital EMS" refers to emergency medical care provided *inside* the hospital, such as in the hospital emergency department (ED). Field EMS remains significantly underfunded and is severely challenged to best serve patients.

EMS At the Crossroads

The landmark 2006 Institute of Medicine (IOM) Report *Emergency Medical Services: At the Crossroads* identified systemic problems that undermine the public trust and reliance upon EMS to protect them in their greatest hour of need. Strong federal funding in the 1970s fueled the initial development of EMS systems at the state and local levels. In the 1980s withdrawal of comprehensive federal funding led to haphazard growth and of EMS systems across the country. While fire and police first responders have several targeted federal support programs, there is no dedicated federal funding for field EMS. Other systemic problems identified by IOM include: insufficient coordination among EMS providers, disparities in response times, uncertain quality of care, lack of readiness for disasters and inadequate federal funding for disaster preparedness, divided professional identify of EMS personnel, and significantly, a limited evidence base of emergency medical interventions.

In many areas, EMS services are highly fragmented, poorly equipped and insufficiently prepared for day-to-day operations, let alone natural or man-made major disasters. EMS is challenged by overburdened hospital EDs – from 1993 to 2003, 425 EDs closed while ED visits rose by more than 25% in the same period. From 1990 to 2005, 30% of trauma centers closed.

EMS is multi-jurisdictional with federal agency responsibility tasked across DHS, HHS, DOT, IHS, FCC and DOD. Federal grant funding for *other components* of EMS (such as hospital preparedness) falls within a variety of programs with multiple

responsibilities and competing priorities. Accordingly, federal funding for EMS is fragmented, limited, and all too often is overlooked in favor of other needs.

Vision for Future of EMS – Forging a Path Beyond the Crossroads

The *EMS at the Crossroads* report envisions a system in which all communities will be well served by well-planned and highly coordinated emergency medical services that are accountable for their performance. Delivery of services for every type of emergency will be seamless. The delivery of all services will be evidence based and innovations will be rapidly adopted and adapted to each community's needs. To achieve that vision, it is recommended:

- *Federal Home for EMS and Trauma* – the designation of a lead Federal agency for EMS and trauma at HHS
- *System Finance* – that CMS evaluate reimbursement for EMS and make recommendations with regard to readiness costs and permitting payment without transport
- *Regionalization* – the development of evidence-based categorization systems for EMS, and EDs based on capabilities as well as evidence-based model, pre-hospital care protocols for treatment, triage, and transport of patients
- *National Standards for Training and Credentialing* – adoption among the states of a common scope of practice for field EMS practitioners with state licensing reciprocity and acceptance of national certification as prerequisite for state licensure and local credentialing of field EMS practitioners and national accreditation of paramedic education programs
- *Enhanced medical direction* – medical oversight and direction should be provided by physicians that meet standardized minimum requirements for training and certification
- *Coordination* – Dispatch, EMS, ED and, public safety and public health should be fully interconnected and united in an effort to ensure that each patient receives the most appropriate care, at the optimal location, with the minimum delay
- *Communication and Data Systems* – develop integrated and interoperable communications and data systems. Integrate field EMS into design deployment and financing of National Health Information infrastructure.

Field EMS Quality, Innovation and Cost-Effectiveness Improvement Act, H.R. 3144

The Field EMS Quality, Innovation, Cost-Effectiveness Improvement Act would provide a path out of the crossroads and toward the vision outlined. *

Training Is Never Just Training

Michael Bachman, NREMT-P, Tactical Paramedic, Wake County EMS

Tactical teams spend a great amount of time training to prepare for actual missions. At the risk of repeating an all too used cliché, “We train like we fight.” We put a lot of effort into difficult and realistic training. This is why a large portion of injuries to tactical operators takes place during training exercises. With this known fact, do we put the same amount of planning into training as we do into real world missions? Do we plan enough for real world missions?

This past year my team was performing a three-day tactical training session on a military reservation in a remote area. During the second night, the team was completing a live fire evolution involving room clearing in a shoot house. An operator deployed a flash bang. The clip designed for keeping the pin in place when stored caught on the end of his sling, causing an unexpected detonation and resulting in a significant blast injury to his hand. He was fortunate not to lose any fingers. He did suffer significant burns, soft tissue injuries, fractures, and neurological damage to his hand. This particular incident was handled well due to good planning, teamwork and the grace of God. I plan to outline some of those things to help others better prepare for incidents either in training or during missions.

Ut ceteri vivant (“So that others may live”)

Before this training session, I knew there were a couple of things that needed to be addressed due to the location and circumstances surrounding the training venue. Here is what we knew.

- There was only one medic present, supplied with ALS and BLS kits normally used on missions
- No ambulance on site
- Closest hospital: 10 minutes, which was a limited facility on a military installation
- Air response: 15 minutes by air
- Closest trauma center: 1 hour by ground
- No direct radio communications with any of the area hospitals

With these facts, a medical threat assessment/emergency action plan was completed in advance. This information included phone contact numbers for local hospital emergency departments, as well as areas that could be utilized for LZs in the event of helicopter evacuation. A written emergency action plan assigned medical role to the operators to assist the single medic in case of a medical emergency. These tasks were broken down into direct patient care, casualty evacuation, and transportation. In this particular case, the van utilized for entries was designated as the transport vehicle for casualties. There were also methods for contacting the security gate at the military installation so passage to the closest hospital could be accomplished. A briefing on the plan was reviewed with all team members just before the training.

This plan was put to the test because of the training injury. Upon the initial incident, without prompting, team members immediately began to perform their medical roles.

The injured officer was rapidly and seamlessly transported to the closest medical facility for initial evaluation. After the full extent of the injuries was determined, he was then transferred to a specialty burn trauma center approximately an hour away for definitive care. I was able to accompany the officer to that facility and remain with him both for personal support and to act as a liaison for our team and agency.

There were several lessons learned as a result:

1. Training is never just training. We cannot get into the mindset that serious injuries are not a risk just because we are participating in training. In fact this is when most of our injuries occur. We have to take the same steps in preparation for a training evolution as we do a real mission.

2. Give distraction devices their due respect. Distraction devices are frequently used in training and during actual entries. These devices achieve the desired effect through an explosive detonation. Therefore, there is always a real potential for injury.

3. Have an immediate action plan for all events. Threat assessment plans do not have to be a complex written plan, but we do have to check the boxes if nothing more than mentally. Know where your closest facility is, how are you going to make contact, what is your method and plan for evacuation etc. Even if you collect this information in your head it is important to share it with your team.

Our team responds with a single tactical medic. I know that if there is a significant injury I will need some help. Develop medical assignments for your tactical operators to assist you. In tactical situations the mission usually lies at the top of the priority list. However, once the mission is complete the primary focus is on the casualty, especially if it is one of your team mates. Without assigned responsibilities it would be easy for chaos to ensue. This assessment must be completed. Plan and brief on it for every training evolution and entry your team deploys on.

4. How you take care of your operator will influence how you are perceived by the rest of the team. I did not do anything heroic or out of the way in caring for my team member. I did what I expected every other medic on my team would have done. I took care of his acute injuries and helped coordinate his transfer. After the initial evaluation at the local hospital, I asked the transporting EMS agency to allow me to accompany him to his final destination at the burn/trauma center. These actions were not anything extraordinary, but in doing my job it was well appreciated at all levels of the police department. I only tell this part to let you know that even little things are recognized and appreciated by your law enforcement team members, all of which builds that team cohesion that we work so hard to fit in to.

In conclusion, this was a serious but not life-threatening training injury. It could have easily been a career-ending event. Regardless it was a significant injury to a team mate and one that deserves the best medical care we can provide. That care is more than placing a bandage and performing other medical skills. Critically, it means pre-planning for the event so that optimal care and efficiency may be achieved.

This officer recently told me that, “if you had asked me 5 minutes earlier if I would ever have been injured by a flash bang I would have told you never in a million years.” He ended the conversation with, “I sure am glad we had a plan and we executed the plan we had.” *



Welcome New Members

- | | | |
|--|--------------------------------------|--|
| Heidi Abraham, MD, EMT | Matthew Hall, BA, NREMT-P | Christoffer Poulsen |
| Andrew Affleck, CCFP(EM), FIFEM | Thomas Lamb Haltom, MD | James N. Pruden, MD, FACEP |
| Hani Albrahim, MD | Stephen Halvorson, MD | Sush Prusty, MD |
| Nashua K. Alexander, EMT-P | Christopher Heppel | Amy B. Raubenolt, MD, MPH, MEd |
| Nawfal Abdullah Algerian, MD | H. David Hinchman, DO, FACEP | Michael Redlener, MD |
| Elizabeth Ann Beal, MD | S. Marshal Isaacs, MD | Charles M. Reynolds, MD |
| James Brasiel | Arthur R. Johnson | Ross Riley, EMT-P |
| Joshua T. Bucher, BA, EMT-B | Troy R. Johnson, MD | Tadd Roberts, MD, EMT |
| Ken P. Buchholz, MD, FCFP | Robert James Katzer, MD | Mark Schueler, MD |
| Charles P. Burnell, MD | Samiur R. Khandker, MD | Don Sheets, NREMT-P, CCEMT-P |
| J. Reed Caldwell, MD, EMT | George James Kovacs | Danniel J. Stites, MD |
| Darryl Calvo, MD | Michele Kuszajewski, RN, EMT-P | Francis Sullivan, MD |
| Christopher J. Case, MS, DO | Ken Lavelle, MD, FACEP, NREMT-P | Michael P. Sullivan, MD, FACEP |
| Srihari Cattamanchi | Douglas Lewis, MD | Robert Sullivan, BA, NREMT-P |
| Richard A. Clinchy, III, BS, PhD, EMT-P | Michael Mancera, MD | Leslie Terrell, RN, EMT-P |
| Joseph David Cordova, MD | Sean W. Marquis, MD, NREMT-P | Colin Thomas |
| Rishona Corson, MD, NREMT-P | Kyle B. McClaine, MD, FACEP | Peter Thyssen, EMT-P |
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| Ann M. Dietrich, MD, FAAP, FACEP | Matthew J. Messa, DO, MPAS, EMT-P | Thomas W. Trimarco, MD |
| Siama Durrani-Tariq | Art Miller, RN, EMT-P | Ted E. Troyer, MD, FACEP |
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| Julia Diane Rebekah Fox, NREMT-P, BS, MSc | Micah Ownbey | Susan R. Wilcox, MD |
| David W. Gammell, EMT-P | Carl Paetzold | Daniel Kevin Wilson, DO |
| Jeff T. Grange, MD | Chang Bae Park | Joseph Louis Wright, MD, MPH |
| | Amar P. Patel, MS, NREMT-P, CFC | Megann Young |

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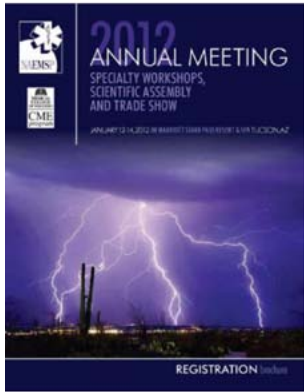
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Jerrie Lynn Kind
Association Manager /
Grants Project Manager,
Stephanie Newman

Meeting Planner,
Megan Finnell
Administrative Assistant
Diane Conner

Current NAEMSP® Annual Meetings



Online Registration is OPEN!

Click [here](#) or the brochure to the left for complete information and the registration form if you wish to submit via fax (913/895-4652) or email info-NAEMSP@goAMP.com.

NAEMSP®'s next Annual Conference will be held at the **JW Marriott Starr Pass Resort & Spa**, January 12-14, 2012

Pre-Conference Workshops:

National EMS Medical Directors Course & Practicum, Monday-Wednesday, January 9-11, 2012

HAZMAT/WMD Training, Monday-Tuesday, January 9-10, 2012

Advanced Topics in Medical Direction (ATMD), Wednesday, January 11, 2012

Distinctly Canadian Workshop, Wednesday, January 11, 2012

Future NAEMSP® Annual Meetings



January 10-12, 2013

Hyatt Regency Coconut Point Resort & Spa
Bonita Springs, Florida

January 16-18, 2014

JW Marriott Starr Pass Resort & Spa
Tucson, Arizona

Other EMS Meetings

**January 6-7, 2012 – Tactical Medicine:
The Israel Experience**

Contact Scott Goldstein if interested:

(215) 456-4571, Email: EC3@einstein.edu,

Web: <https://www.trainingcentermanager.com/Einstein/Default.aspx>

*Be sure to check out the most updated version
of the EMS Calendar at www.NAEMSP.org.*

Fellowship in Emergency Medical Services and Disaster Medicine at UCSF

University of California, San Francisco, Department of Emergency Medicine is seeking applicants for a fellowship in Emergency Medical Services and Disaster Medicine for July 1, 2012. Fellows will serve as HS Clinical Instructors at San Francisco General Hospital, a Level 1 Trauma Center with 65,000 visits yearly and a fully implemented 4 year Emergency Medicine residency.

This fellowship offers both 1 and 2 year options. The program combines EMS with Emergency Management/ Disaster Medicine while working with the SF EMS Agency. There are opportunities to work with externally funded faculty as well as take part in the EMS education of local paramedics and the UCSF EM residents.

The two year program offers a master's degree, typically in Public Health or Clinical Research among others. Salary is commensurate with PGY level. Completion of an ACGME accredited EM residency is required prior to start. Send CV, Statement of interest and three letters of recommendation by September 1, 2011 to:

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