



## *Bending the Rules* What To Do When EMS Protocols Don't Fit

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### Introduction

Perhaps the most frequently asked question of us when speaking at a paramedic training program or attending an EMS conference concerns what an EMT or paramedic ("medic") should do when he/she feels that following the EMS protocols would either harm the patient or that the protocols simply don't apply. How serious an issue is this for the emergency department physician providing telemetry direction or the EMS medical director? *Very!*

Although this scenario doesn't arise as often as some may believe, it can affect you in many ways. First, your medics are treating patients for whom you may have medical responsibility. Second, you may also have legal responsibility for the patient's real or perceived poor outcome. Third, if you played a role in the medic's training or continuing education, this could give rise to a negligent training or supervision claim against you.

Medics usually operate under rules adopted by an EMS medical director or a similar person or group. Those rules, often called protocols or standing orders, determine what treatment the medics should provide for any given illness or injury. These protocols should control the overwhelming majority of calls the medics under your supervision handle and the medics should strive to follow the protocols on every call.

Yet at the same time, protocols are really just guidelines. Indeed, many protocols include introductory remarks noting that the medic must still exercise judgment, directing the medic to contact medical control if questions arise about protocol applicability and stating that protecting the patient's health and sta-

bility should always be the primary objective. These types of remarks are important reminders not only for the medics, but also for you. Blindly following an inappropriate protocol may have consequences for both of you. At the end of this article, we will suggest a few things you can do to protect the patient, the medic and yourself.

Even the best protocols cannot anticipate every contingency. Accordingly, your medics may find themselves in a situation where they believe they should deviate from the protocols. This decision is a serious one. Consequences may include the potential for both civil liability and disciplinary action for the medics and ED physicians. How the two of you handle this situation will likely affect what consequences may result, if any.

We tell medics that there are three things they should remember in these situations: discuss, document and disclose. These steps should help them think through the decision and will show those who review the case that the medics understood the importance of their decision and tried to make the right choice under the circumstances.

### When Does the Protocol Deviation Issue Arise?

A protocol deviation issue may arise when the medic concludes that following the protocols would be against the patient's best interests. For example, a medic may conclude that he/she needs to administer a cardiac drug differently from the way it is prescribed in the ACLS algorithm, or reduce a dislocated joint when the protocols do not provide for that procedure. Note an important dis-

inction between these examples. In the first, the medic knows how to administer cardiac medications and is even familiar with that specific cardiac drug. It is his/her use of the drug in an un-prescribed manner that is contrary to protocol. In the second, the medic may have received no formal training in reduction of the joint, but is convinced he/she must try something because they are an hour from the hospital and the extremity is cold and pulseless.

In either case, the medic's response should be the same. The first task is to discuss the situation. Ideally, the medic should get a "reality check" by discussing it with his/her partner. More importantly, the medic should discuss the proposed deviation with the ED physician and seek the physician's assent. This will force him/her to think it through. If the medic cannot explain it in a way that persuades his/her partner and you, then perhaps the protocol should indeed be followed. If you as the

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# Mentorship of EMS Physician Specialists

As I mentioned in my last column, the idea of starting a mentorship program within the association has been expressed by several members recently. The comments have come both from folks who would like to have a mentor and folks who would like to be a mentor. And, we have recently been asked if there is a "resident" group within NAEMSP. As I mentioned previously, the idea of being a "mentor" made me personally uncomfortable ... until someone revealed to me that I was his or her "mentor." I was mentoring someone without even realizing it! And I suspect that many others in our association are mentors, consciously and unconsciously. It is exciting that members of NAEMSP are looking for this service, exciting that more residents are interested in active involvement in the organization, and exciting that we have this opportunity.

In thinking back on this idea, I realized that there are many reasons for doing this. A couple of years ago, there was a concerted effort among NAEMSP, the American College of Emergency Physicians (ACEP), the Society for Academic Emergency Medicine (SAEM) and other organizations, supported by the American Board of Emergency

Medicine (ABEM), to investigate the possibility of establishing subspecialty recognition of EMS. This eventually didn't come to fruition because it was felt that there were not enough "special aspects" of EMS to justify the need for subspecialty training in EMS. Part of that decision was based on a feeling that the "clinical" difference between EMS and emergency medicine was minimal. Many of us were disappointed by this decision, as we recognized that there are many unique aspects of EMS that are not adequately addressed in EM residency and are not addressed at all in any other medical specialty. It takes unique knowledge and skills to function as an effective EMS physician. This fact is reinforced with these recent requests for mentors for new EMS physicians.

In looking for information on mentorship, I have found things in recent ACEP and SAEM resources, on the Web and within our EMS residency. That must mean other organizations are also looking at this issue closely. Supposedly, Homer described the original mentor as the "wise and trusted counselor." A mentor can also be described as an individual who takes a special interest in helping others develop into successful



Jon R. Krohmer, MD

professionals. This is exactly what we want to accomplish. Being a good mentor allows one to achieve satisfaction, attract good mentees, stay on top of the field, develop a larger professional network, and extend his or her contribution to the profession. There is a very nice brief reference regarding the mentorship process in the August 1999 issue of *Annals of Emergency Medicine*\*.

As we move forward in this program, there will be more information available to our membership, both those who will be tapped as mentors and those looking for a mentor. Having said that, it is time for each of you to identify which group you fit into. Please respond to either me ([kcems1@aol.com](mailto:kcems1@aol.com)) or President-elect Dr. Rick Hunt ([huntr@upstate.edu](mailto:huntr@upstate.edu)) about your interest in the process and your thoughts about how to help this program evolve.

What this also means is that there really is a need for EMS subspecialization, as there are many unique aspects of being an effective EMS physician that do require special knowledge and skills. The association will continue to explore aspects of this and investigate other potential options for recognition of that "unique body of knowledge" possessed by EMS physicians.

*Special note: For the professional members of NAEMSP reading this who are concerned that this issue is only for the physician members, guess again. Although I have focused on the physicians in the above discussion, it also applies to professional members, and you will all be included in this process!*

\* Osborn TM, Waeckerle JF, Perina D: Mentorship: through the looking glass into our future. *Ann Emerg Med* 1999;34:285-289. \*

### **The National Association of EMS Physicians is an organization of physicians and other professionals who 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.

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Articles for inclusion in the newsletter must be submitted by e-mail or on diskette (WordPerfect or Word). To submit material for publication, contact the editor by telephone or e-mail.

#### **NAEMSP News**

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#### **Copy Deadlines**

November 2000 issue: *September 27, 2000*

January 2001 issue: *November 27, 2000*

ED physician agree, then you should carefully document the discussion and decision in the patient's telemetry record. We also tell the medic to document this fully in the run report. This must include the findings, the decision, and a notation that the ED physician has approved the action.

Finally, we tell medics to disclose their actions when transferring the patient to the hospital staff. If the receiving physician is the one who has authorized the protocol deviation, then he/she should sign the medic's call sheet. If the patient is transported to a different facility than the one at which the authorizing physician works, then the medic must inform not only the authorizing physician, but also the staff at the receiving hospital, emphasizing that the medic received approval from a physician at another facility.

### When Approval to Deviate Cannot Be Secured

What if the medic cannot secure approval either because the ED physician does not agree or because radio or telephone communications are unavailable? The same three steps, "Discuss, Document and Disclose," are equally, if not more, important. If the medic cannot contact the ED physician, he/she should do the following: 1) discuss the situation with his/her partner; 2) consider the patient's condition and proposed actions; 3) if they are sure that following the protocol would be detrimental to the patient, proceed with treating the patient in accordance with their best professional judgment.

This situation is obviously difficult and the decision should not be made lightly. We tell medics that while protocols are to be followed, if they conclude that following the protocols would have a serious, detrimental effect on their patient, then they have a duty to act. Medics are trained to use their best judgment and make tough decisions under pressing circumstances. This includes

ensuring that they do not blindly follow protocols when doing so may harm the patient.

The next step, documentation, is perhaps even more critical. Failure to document the decision may be viewed – rightly or wrongly – as an attempt by the medic to cover up improper conduct. If the medics believe they are right, we urge them to make sure the documentation will allow others to understand and follow their thought processes. Finally, medics should disclose their actions as soon as possible, ideally by radio or phone contact while en route to the hospital. They should inform both the telemetry physician and the receiving ED staff of their actions and their reasoning.

What happens if the medics contact an ED physician and he/she denies their request? We tell medics that the need for documentation is equally important. We suggest they document their findings and recommendations, including what they told the ED physician and the response. They should disclose to the receiving facility what actions they did and did not take, especially if the receiving facility was not the one issuing the orders. This situation may also arise when the patient's personal doctor has given orders that conflict with their protocols. If the telemetry physician was not the medics' medical director, that physician is best notified as well.

### Consequences of Deviating From the Protocols

Failing to follow protocols may lead to adverse consequences for both the ED physician and the medic. First, if there is a poor outcome, a lawsuit may be filed. The plaintiff will soon learn that the protocols were not followed. Although the medics may have had approval for their action, the plaintiff will likely try to use the deviation against both them and you. If the decision to deviate was correct, your lawyer can use that fact to demonstrate that the medics and you, if you gave approval, were not blindly following protocols that may have been

harmful. In some jurisdictions where plaintiffs must prove that medics have acted willfully and wantonly, rather than merely negligently, a lawyer may try to argue that the deviation from the protocol was itself willful and wanton. We know of no case where this argument has prevailed, however. The other potential consequences include disciplinary or peer review actions.

### Recommendations for ED Physicians

We recommend that ED physicians and EMS medical directors take steps in advance so that when these issues arise, both you and your medics will know how to deal with the uncertainty. First, review the protocols and brainstorm with your EMS coordinator and/or medic supervisor to identify likely circumstances in which this situation might arise. This step alone may go a long way toward avoiding the need to deviate.

Second, your medics need to hear from you that you recognize that it may be necessary to deviate from protocols on rare occasion. You and your medics should plan what they should do when they believe they must deviate from protocol. Among other things, this should address how to communicate during the event to avoid the medics having to take the decision solely upon themselves.

Third, make sure that everyone – the medics, the hospital staff, etc. – understands all the steps that must be taken at the time of patient delivery, including complete charting and explanation to staff. Finally, the best plan of all will be for you and the other ED physicians to know your medics as well as possible so that when the call comes in asking for your authority to deviate from the protocol, you will know exactly who is calling and whether you have the confidence you need in that medic to approve this decision. \*

Editor's Note: The above article represents the views of the author and not necessarily those of NAEMSP or its members.

## NAEMSP Welcomes New Members



Preston Ball, MD  
Kurt Bernhisel, MD  
Richard Cutchin, MD, MPH  
Thomas Doyle, MD  
Don Hunt, ENT-P, RN  
Peter Leduc  
Cledwyn Lewis, MD  
Thomas Matese, DO, FACP

Joseph Ornato, MD  
David Sawyer, MD, JD, FACEP  
Harold Spangler, MD  
Rudy Vandersluis, MD, CCFP(EM), FRCPC  
Sandra Werner, MD, MA, EMT-P  
Phillis Willoughby, NREMT-P  
Wade Woelfle, MD, FAAEM  
Barak Wolff, MPH

# NAEMSP 2001 Annual Meeting

Sanibel Harbour Resort & Spa ■ Fort Myers, Florida ■ January 18-20, 2001

The NAEMSP 2001 Annual Meeting will feature the following hot topics and speakers that you won't want to miss:

- Dr. Ricardo Martinez, senior vice president of Health Affairs at Healthon/WedMD and former director of the EMS Division at the National Highway Traffic Safety Administration (NHTSA), will present the C.J. Shanaberger Memorial Lecture and Keynote Address.
- The Seminar on Medical Direction will focus on problems and needs specific to that of the medical director.
- The popular EMS System Showcase will feature EMS systems from Red River, New Mexico, and Seattle, Washington.
- Tracks in *Advances in Prehospital Airway Support; Preparedness Initiatives for Urban Terrorism; Prehospital Education; and Prehospital Equipment Evaluation.*
- Four hours of cutting-edge EMS research presentations.

*Please see the enclosed flyer for the complete 2001 Annual Meeting Preliminary Program.*

## Reminder Nominate Your EMS Fellow for the New NAEMSP EMS Fellowship Recognition Award

In 1999, the NAEMSP Board of Directors voted to create an award to recognize those physicians who had completed bona fide fellowships in emergency medical services. Discussions at meetings of both EMS fellowship directors and the board of directors led to the realization that this was a way NAEMSP could acknowledge the demonstrated commitment and accomplishments of these distinguished EMS physicians.

To be eligible for the recognition award, the physician must have completed the EMS fellowship after June 30, 1999, and be nominated by his or her fellowship director. **Nomination forms may be obtained from the NAEMSP Executive Office by calling (800) 228-3677, ext. 448, or e-mail to: [info-naemsp@goAMP.com](mailto:info-naemsp@goAMP.com).** Using this form, fellowship directors must indicate that the graduated fellow has acquired expertise in several areas of EMS medical direction and has fulfilled a research requirement. Additionally, both the fellowship director and the EMS fellow must be members of NAEMSP.

Now is the time to look toward our January 2001 Annual Meeting, when NAEMSP hopes to acknowledge several recently graduated EMS fellows. Fellowship directors should be guiding fellows toward completion of projects and ensuring that last year's graduates fulfill leftover obligations.

**Again, nomination forms can be obtained from the NAEMSP Executive Office. The submission deadline for the January 2001 awards is December 1, 2000.**

## We Bid Farewell to Our Association Manager – Beth Panther

Beth Panther is leaving our association at the end of September, awaiting the birth of her third child. Little Panther is expected to join her two brothers, Erik and Zachary, and her father, Matt, in November. Everyone is thrilled that the baby is going to be a girl (finally, Beth will have better gender odds on the home front!).

Beth has served as NAEMSP's Association Manager since April 1997 when the Executive Office relocated from Pittsburgh, Pennsylvania to Lenexa, Kansas, a suburb of Kansas City. The staff and board of directors will miss her problem solving and critical thinking skills, friendly attitude, ability to think on her feet and her rapier wit. Beth committed herself intensely to the work of NAEMSP and made many invaluable contributions in her three years with the association. We wish Beth and her family the very best, especially that the little girl making her way into this world is healthy.

# Elections

## NAEMSP Board of Directors

### For Terms January 21, 2001 – Annual Meeting January 2003

An official election ballot is on page 7 of this newsletter

The NAEMSP Nominating Committee, chaired by Immediate Past President Robert Swor, DO, is pleased to present you with the following exceptional candidates for the open positions on the NAEMSP Board of Directors. The Nominating Committee received over 25 interested candidates for the three open physician and professional member-at-large positions, so choosing the slate was difficult. However, the committee was very pleased to receive so much interest in serving on the board. We encourage all of our members to be active and involved in our association.

Candidate biographies are included on the following pages. The ballot can be found on page 11. The NAEMSP Board of Directors candidate slate is as follows:

- President-Elect (vote for one): Robert Bass, MD, FACEP  
Secretary-Treasurer (vote for one): Theodore Delbridge, MD, MPH  
Robert O'Connor, MD, MPH  
Physician Member-at-Large (vote for two): Robert Domeier, MD  
Craig Key, MD, FACEP  
Greg Mears, MD, FACEP  
James Pointer, MD  
Keith Wesley, MD, FACEP  
Professional Member-at-Large (vote for one): Beth Adams, MA, RN, NREMT-P  
Jerry Overton, MPA

The candidates listed above are physician and professional members in good standing with the association and have agreed to serve the membership and the best interests of the association if elected.

In the case of a tie in voting, another mail ballot will be issued for those candidates involved in the tie. If a tie results after two ballots, the NAEMSP Board of Directors shall determine the winner by a simple majority vote of the members of the board.

The voting will close at 5:00 p.m. CST on **Friday, October 27, 2000**. Only the original ballot contained in this newsletter will be accepted. A facsimile or copy of the official ballot will not be accepted or counted as a vote. A return envelope is included with this newsletter, although a plain envelope may be used.

Voting is open to all physician, professional, resident and fellow members of the NAEMSP in good standing. Medical students and honorary members are not eligible to vote.

*Thank you for taking time to place your vote for the NAEMSP Board of Directors.*

## Statements From the Candidates

### PRESIDENT-ELECT

#### **Robert R. Bass, MD, FACEP**

It is a great honor to be nominated as president-elect of NAEMSP. I have watched this organization grow in both membership and stature since our first meeting in 1984. As we approach our 20th anniversary, we can be proud of our achievements as we look to more challenges and successes in the future.

For those of you who do not know me, I am an emergency physician and have served as a medical director for EMS systems since 1978. I began my EMS career in 1970 as a volunteer EMS provider in Chapel Hill, North Carolina, where I worked as a police officer. Since 1994, I have served as the Executive Director of the Maryland Institute for EMS Systems (MIEMSS) and the state EMS director in Maryland. I have had the pleasure of serving you on the NAEMSP Board of Directors since 1995 and as the secretary-treasurer for the past two years.

In the early part of this past decade, one of our EMS visionaries, Jim Page, suggested that the era of the 90s would see EMS mature, but without the rapid growth that was the hallmark of the previous two decades. I believe that prediction has come to pass, but while EMS systems have been maturing, we are still challenged by a need to measure the outcome of patients treated

by EMS. We still need to answer the many questions about what interventions make a difference in the out-of-hospital setting and what are the EMS system variables that maximize patient outcome. NAEMSP and our journal, *Prehospital Emergency Care (PEC)*, have and will continue to provide a key forum for answering those questions. The position papers of the association are concise, science-based summaries of current EMS issues, developed by the collective expertise of our membership. *PEC* and our position papers now serve as an important source of information for EMS physicians seeking guidance as they make difficult medical decisions that must be based on timely and reliable information.

NAEMSP is also providing leadership on many national EMS issues. In the past year we have participated in the negotiated rule making process for the new Medicare ambulance fee schedule. The fee schedule's and other Medicare policy's impact on EMS need to be carefully monitored as new rules are promulgated and implemented. Many components of the *EMS Agenda for the Future*, written by NAEMSP for the National Highway Traffic Safety Administration (NHTSA), will be addressed in the coming years. We are also participating in an exciting discussion with the American Public Health Association (APHA) looking at the role of EMS in public health.

At the association level, we must continue our efforts to increase our professional membership, which has enriched our

deliberations on EMS issues. We also must continue to reach out to the front line EMS physicians, to be a resource to them and to involve them in the work of the association. NAEMSP is a unique organization and the only one that I know that has enabled a diverse assemblage of professionals and physicians to come together and promote quality EMS care. That is our strength and that must be our future.

## SECRETARY-TREASURER

### Theodore Delbridge, MD, MPH

Like all organizations of its size and caliber, NAEMSP continues to mature. Parts of the process include solidifying its membership, focusing on its mission, working responsibly to advance the interests of its members, and planning for the future.

As a member of the board of directors, I have played a role in a number of decisions over the past few years that have been intended to improve our organization and help to ensure its bright future, which will hopefully continue to be meaningful to all of us. Among them have been decisions to engage in political processes and federal initiatives. These have and continue to include efforts to improve reimbursement to EMS, develop important curricula, and create agendas for discussion, investigation and action. With each endeavor, NAEMSP members have worked to enhance our abilities to serve our communities at home.

After extensive deliberation, literally over the course of years, NAEMSP moved to conducting a single general membership meeting each year. We are now in the period of making that decision work for us. While saving in terms of meeting planning expense, we must enjoy increased revenue generated during a single meeting. Our programs and venues must be attractive to our members and to others who have come to recognize NAEMSP's meetings as places to be to get the nation's EMS work done. As our membership ranks continue to slowly grow, NAEMSP must continue to strive to be an organization that eagerly invites active participation by its members.

As with most memberships, there is a cost. Recently, it became necessary to increase the cost of membership in NAEMSP. The secretary-treasurer's priority must be to ensure that your dues dollars are being responsibly spent and represent value to you.

The next treasurer will be charged with overseeing implementation of the organization's new investment policy. As the next secretary-treasurer looks to NAEMSP's future, he or she must be prepared to ensure that all of the organization's investments produce acceptable yields. Sometimes these yields will come in the form of monetary returns and other times they will be less tangible. Nevertheless, they must always provide value to NAEMSP and its members.

For two terms I have enjoyed the privilege of serving NAEMSP as an at-large member of the board of directors, providing me with a useful perspective as we move forward. As the Medical Director of STAT MedEvac in Pittsburgh, I oversee a \$19 million annual operating budget for a system that continues to be strong. I believe that my educational background in health services administration, my working knowledge of budgetary processes at STAT MedEvac and the Department of Emergency Medicine at the University of Pittsburgh, my experience with working with our federal partners during the *EMS Agenda for the Future* project and its follow-up activities, and my history of participation within NAEMSP would be assets as secretary-treasurer. I look forward to the possibility of the privilege of continuing to

serve our organization in that capacity, and to an always-bright future for NAEMSP.

### Robert E. O'Connor, MD, MPH

I have accepted the nomination for the office of secretary-treasurer because I believe this is the best way for me to effectively serve NAEMSP. I am writing a brief biography to provide a basis for your support of my candidacy.

I first developed an interest in the Medical Direction of EMS during my residency in emergency medicine, and have since then served as Medical Director for both county and state-wide agencies. I have written medical treatment protocols, trained medical dispatchers, overseen paramedic quality management programs, taught educational programs for EMT-P's and EMT-B's, and worked with our state legislators on implementation of the Delaware State-Wide Trauma Plan. I started the EMS Fellowship Program at Christiana Care Health System and served as its Director. I currently serve as Director of Medical Education and Research for the Department of Emergency Medicine at the Christiana Care Health System.

I have served NAEMSP as a member of the board of directors since 1996, both as the chair of the Standards and Clinical Practice Committee and as a member-at-large. Our committee wrote a number of position papers on such topics as the *Pneumatic Anti-shock Garment*; *EMS Managed Care*; *Personal Protection*; and *Medical Direction*. I also served as one of the Principle Investigators on the EMS Partnership for Children Performance Contract, which produced the *NAEMSP Model Pediatric Protocols*. I have represented NAEMSP at the EMS-C Pediatric Practice Guidelines and Outcomes Research for Emergency Medical Services, at the NHTSA Consensus Workshop on the Role of EMS in Injury Prevention, the Model Plan for Statewide Quality Improvement Efforts, and the Bethesda: Emergency Cardiac Care Conference. I represent NAEMSP as a member of the board of directors of the National Registry of EMTs and serve on that organization's Practice Analysis Committee, Data Utilization and Information Technology Committee, EMT-P Standard Setting Committee and Credentials Committee. I serve as an Associate Editor to *Prehospital Emergency Care* and have been a frequent contributor to the journal.

My vision is that the future for NAEMSP offers tremendous opportunity, and that we, as an association, must rise to the occasion. NAEMSP is widely viewed as a cohesive voice for physician medical direction of EMS. In the coming years, we must strive to become the premier research association in EMS, with our meetings attracting the most important and innovative papers. These high quality presentations would be a showcase for the annual meeting, would maintain a strong journal, and promote the evidence-based practice of EMS. Research strength should also help attract grants for EMS research, which will sustain the association and foster growth. NAEMSP cannot ignore the fact that many in EMS are looking to us for guidance and leadership.

I believe these opportunities should be pursued to benefit the membership. I will work to enhance the level of services provided to the association's membership by facilitating medical director career development and expanding member services. As the secretary-treasurer, I will work for you to champion the cause of EMS Medical Direction by working to expand the position of NAEMSP in areas of research, education and leadership on the national level, and to assist medical direction on the local and regional level. Thank you.



# PHYSICIAN MEMBER-AT-LARGE

## Robert Domeier, MD

I am seeking your support for my candidacy to the NAEMSP Board of Directors. I have been an active member of NAEMSP since 1991, the year I attended the EMS Medical Director's Course, and have attended nearly every meeting of the organization since that time. I believe that NAEMSP is an important organization to the future of EMS, and I feel that selecting members for the board with a history of strong support for the organization is important to a successful future for NAEMSP.

I attended college at the University of Michigan and went to medical school at Wayne State University, graduating in 1984. I completed my emergency medicine residency at Detroit Receiving Hospital in 1987 and have been at Saint Joseph Mercy Hospital since then. I am currently the EMS Medical Director for the Washtenaw/ Livingston County Medical Control Authority (MCA) and for the Western Wayne County MCA. I am also the Medical Director for Midwest MEDFLIGHT based at Saint Joseph Mercy Hospital.

I have been active in the committee process and have contributed to NAEMSP with committee participation, presentations and position papers for the organization as follows:

- 1995 "PASG Position Development Forum", National Association of EMS Physicians, San Diego, CA, July 1995.
- 1995-Present National Association of EMS Physicians, Standards and Clinical Practice Committee.
- 1996-1997 National Association of EMS Physicians, Program Committee, NAEMSP '97 Annual Meeting, January 1997, Naples.
- 1996-1997 National Association of EMS Physicians, Program Committee, Chair, NAEMSP Annual Conference and Scientific Assembly, July 1997, Lake Tahoe.
- 1996-Present National Association of EMS Physicians, Educational Programs Committee.
- 1996-Best Poster, National Association of EMS Physicians, Scientific Meeting: Domeier RM, Evans RW, Swor RA, Hancock JB, Fales W, Krohmer J, Frederiksen SM, Shork MA: *Mechanism of Injury is Not a Factor in Prehospital Clinical Evaluation of Potential Spine Injury.*
- 1997 Domeier RM, O'Connor RE, Delbridge TR, Hunt RC: Position Paper, National Association of EMS Physicians: *Use of the Pneumatic Anti-Shock Garment (PASG).* *Prehospital Emergency Care* 1997;1:32-35.

1997 "Prehospital Clinical Spine Clearance Position Development Forum," National Association of EMS Physicians, Lake Tahoe, NV, July 1997.

1998-Present National Association of EMS Physicians, Standards and Clinical Practice Committee, Chair.

1999 Domeier RM: Position Paper, National Association of EMS Physicians: *Indications for Prehospital Spinal Immobilization.* *Prehospital Emergency Care* 1999;3(3): 251-253.

I have served on the NAEMSP Board of Directors as the Standards and Clinical Practice Chair since 1998 and have gained experience and an appreciation for the work necessary to be an active board of directors contributor. I look forward to continued service to the organization and feel its mission is important to the EMS community. I appreciate your support for my election to the NAEMSP Board of Directors. Thank you.

## Craig B. Key, MD, FACEP

I am honored to be nominated for the board of directors of the National Association of EMS Physicians. Should I be elected, I view this as an opportunity to give my time to an organization that I feel is important to the future of EMS. As we move forward with new concepts, such as the national agenda for EMS, this is an exciting era for NAEMSP.

While a college student at LeTourneau University in Texas, my EMS career began as an ambulance attendant with the Longview Ambulance Service. I moved back to Ohio and completed my undergraduate education in electrical engineering at Ohio State University. Following college, I worked as an engineer in industry and as a paramedic/firefighter in Ohio.

Five years later, I attended the Medical College of Ohio and earned my medical degree while serving my community as a firefighter/paramedic in a rural community near Toledo, Ohio. My emergency medicine residency was completed at Orlando Regional Medical Center in Orlando, Florida.

Following residency, I did a fellowship in EMS with Paul Pepe in Houston, Texas. For the last five years I have been the associate medical director for the Houston Fire Department and on the Emergency Medicine faculty at the University of Texas, Houston. I was also on the faculty at Baylor College of Medicine in Houston during this time.

Currently, I am in transition to Ohio where I will join the faculty of the Ohio State University in the Department of Emergency Medicine. I plan to continue my involvement in EMS

**Official Ballot**  
NAEMSP Board of Directors Election  
Term: January 21, 2001 - Annual Meeting, January 2003

**Note: Medical students and Honorary members are not eligible to vote.**

Please use the envelope provided with this newsletter or your own envelope to mail your completed election ballot to: NAEMSP, P.O. Box 15945-281, Lenexa, KS 66285-5945. Overnight mail ONLY should be directed to: NAEMSP, 8310 Nieman Road, Lenexa, KS 66214.

**Ballots must be received by 5:00 p.m. CST on Friday, October 27, 2000, to be counted.**

Facsimiles or copies of the official ballot will not be accepted. Contact the NAEMSP Executive Office at (800) 228-3677 if you have any questions.

For President-Elect (*vote for one*):

- Robert Bass, MD, FACEP
- Write-in Candidate: \_\_\_\_\_

For Secretary-Treasurer (*vote for one*):

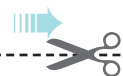
- Theodore Delbridge, MD, MPH
- Write-in Candidate: \_\_\_\_\_
- Robert O'Connor, MD, MPH

For Physician Member-at-Large (*vote for two*):

- Robert Domeier, MD
- James Pointer, MD
- Craig Key, MD, FACEP
- Keith Wesley, MD, FACEP
- Greg Mears, MD, FACEP
- Write-in Candidate: \_\_\_\_\_

For Professional Member-at-Large (*vote for one*):

- Beth Adams, MA, RN, NREMT-P
- Write-in Candidate: \_\_\_\_\_
- Jerry Overton, MPA



with a number of agencies in the Columbus area.

I am an active member of NAEMSP, having served on the Nominating Committee, the Technology Task Force and the EMS Fellow and Fellowship Graduates Task Force. I have also lectured at the NAEMSP annual meeting. My research is in the area of EMS dispatch, EMS system design and resuscitation.

I would like the opportunity to serve you and the other members of NAEMSP. I believe that my diverse background with EMS systems from rural volunteer to suburban and large urban systems makes me sensitive to the needs of many EMS organizations and medical directors. Should I be elected, I will work hard to advance EMS and the National Association of EMS Physicians.

Thank you for your consideration.

## Greg Mears, MD, FACEP

I would like to introduce myself and request your support as a candidate for a physician member-at-large position on the NAEMSP Board of Directors. I have had the opportunity to witness, participate, and observe NAEMSP as it has developed into one of the most respected and influential EMS organizations in the country. Membership has grown to over 1,100 with relationships being initiated and fostered with major physician, non-physician and governmental representatives in prehospital medicine. I would like to share my career experience that I believe will allow me to represent EMS physicians in a professional and knowledgeable manner.

Upon obtaining my MD degree from the University of Missouri-Kansas City in 1985, I completed an Emergency Medicine Residency at the North Carolina Baptist Hospital with Wake Forest University in Winston-Salem, North Carolina. After finishing residency in 1988, I joined a 12-member physician practice in Springfield, Missouri. In 1992, I relocated to Chapel Hill, North Carolina, where I was appointed Head of the Division of EMS, while a new Department of Emergency Medicine was formed. Currently, I have an academic appointment as Associate Professor in Emergency Medicine.

As a third-year medical student and throughout residency, I became actively involved with rural EMS. As a local system medical director since 1988, I continue to promote and advocate new EMS concepts. I have presented the Orange County, NC pilot program at NAEMSP's annual conference. A unique EMS structure was created whereby EMS treatment and transport

were completely separated. Formal protocols were instituted to dispatch ambulances only when needed, allowing paramedics in quick response vehicles to manage calls with low probability of transport. Development and validation of formal protocols allowed paramedics to make treat and release decisions. Introducing injury prevention to Orange County via the *Welcome to the World Project* allows a paramedic to conduct newborn home visits while performing a safety inspection. These projects were designed with a patient outcome and community health perspective.

Two years ago I was appointed the North Carolina Medical Advisor, allowing me to interact with, support and promote local EMS systems. Since 1998 I have chaired the NAEMSP Rural Affairs Task Force, which promotes issues and concepts important to non-urban EMS systems. I also represent NAEMSP on several national initiatives that include the National Rural Health Association (NRHA), National Association of State EMS Directors (NASEMSD) National EMS Database initiative, and the EMS-C National Pediatric Trauma Registry project.

From a research perspective, I am the principle investigator for the North Carolina Prehospital Medical Information System (PreMIS). This is a four-year, \$1.5 million project funded by the Governor's Highway Safety Initiative to create an electronic medical record system for all North Carolina EMS services. Additionally, I serve as the principle investigator for an NHTSA/NASEMSD project entitled: EMS Reason for Encounter. This two-year funded project is focused on developing an EMS coding or classification scheme that will allow EMS patient encounters to be objectively grouped for quality management, research, reimbursement and/or public health surveillance initiatives.

EMS is a dynamic, complex entity that can only survive with an innovative and progressive approach. Regardless of an EMS system's size or structure, common issues regarding finance, labor and resources are critical to us all. Successful NAEMSP growth strategies must include heightening our professional organization's visibility, availability and responsiveness to local medical directors as well as local, regional and national initiatives. To that end, our professional NAEMSP membership will increase, as will our influence and capacity to enhance customer service to our association and our patients. I would appreciate your vote.



Detach and return the  
completed election ballot  
on the opposite side of this page  
by 5 p.m. CST on Friday,  
October 27, 2000

## James E. Pointer, MD

I am honored that the Nominating Committee has placed my name on the ballot for the physician member-at-large position on our NAEMSP Board. I have been involved with NAEMSP since 1985; the organization has changed a great deal in that time. It truly represents not only EMS physicians but also administrative personnel, out-of-hospital providers, nurses and the fire community. It is because of these changes that I am particularly challenged and interested in serving on our organization's board.

I have been involved in emergency medical services since 1975. Currently, I am the Medical Director for Alameda County (for the second time in 18 years). I was San Francisco's full-time medical director from 1988-1993. In 1993, I moved to Florida to learn to fish and try to make some money (that I never made in EMS). Neither undertaking was successful. My wife, 9-year-old daughter and I have been back in California for several years. I hope to bring some of my experience as medical director in two states and nine jurisdictions to our organization.

I served a two-year stint as Education Committee Chair for NAEMSP beginning in 1992. My research interests include paramedic triage, demographics and characteristics of frequent users of emergency services, competency issues involving new and inexperienced paramedics, and broadening and helping to legalize prevention activities for out-of-hospital providers.

If elected to the board, I will work to ensure that our organization continues its leadership role in EMS. I believe that NAEMSP must take further written positions on controversial but important issues that affect the care of our patients. Also, I believe the organization should facilitate the integration of state EMS organizations, and perhaps, develop NAEMSP state chapters. With the rapid growth of our fine journal, *Prehospital Emergency Care*, there is no better time to promote and extend the message of our organization. I will never hesitate to speak out for excellent out-of-hospital care, always under the direction of responsible and appropriate medical leadership. I hope you will consider giving me one of your votes!

## Keith Wesley, MD, FACEP

NAEMSP possesses a distinctly unique opportunity to shape the future of prehospital medicine, and I believe that I possess the qualities necessary to represent your interests on the board of directors. The association must foster collaboration with organizations such as NAEMSE, NAEMSD, ACEP, the National Registry and any organization representing a facet of EMS. It must remain strong in support of research as well as the development of educational programs for its members and the EMS community.

After graduating from Brigham Young University in 1982, I attended Baylor College of Medicine in Houston, Texas. Working with some of the pioneers of surgery and EMS reinforced my desire to pursue emergency medicine. I completed my emergency medicine residency at Methodist Hospital of Indiana in 1989 where I had the opportunity to develop my interest in EMS for mass gatherings.

In 1989, after moving to Wisconsin, I assumed my first medical direction role with a small rural EMS service and soon discovered that this was my passion. I became more involved in local and regional EMS policy development and in 1994 was appointed by Governor Thompson to the newly created EMS Physician Advisory Committee. I am now serving my third term with this body that advises the Wisconsin Bureau of EMS and sit as its chairman. In 1995, I edited and published the first medical directors handbook with the state EMS office.

In 1995, I was appointed the medical advisor to the Wisconsin EMS Association. With almost 3,000 EMTs, EMS physicians and nurses, it is the single largest association of its kind in the Midwest. I have had the great pleasure to publish a regular "Hey Doc" column in its official magazine, *The Professional*, for the past four years and speak at its annual conference.

Since 1995, I have practiced emergency medicine at Sacred Heart Hospital in Eau Claire, Wisconsin, a rural-suburban community of 50,000. I am the medical director of the Eau Claire Fire Department, the regional HAZMAT team, county 911 center and co-director of the county EMS program.

Education represents one of the most rewarding activities in EMS as I discovered as medical director of EMS education at our local technical college. I have been actively involved in the development and implementation of the EMT-Intermediate and Paramedic curriculums in Wisconsin and serve as a site visitor for the Committee on Accreditation of Educational Programs for EMS Professions, formally the Joint Review Committee.

Working in a community hospital and participating in state-wide EMS development has brought me an understanding of the issues facing the average medical director. Research, education, quality improvement and systems management all compete for our attention. Our organization must remain committed to providing EMS medical directors with the tools necessary to do their jobs well at all levels. It is this perspective that will allow me to serve you honestly in the leadership of NAEMSP. Thank you for your support.

## PROFESSIONAL MEMBER-AT-LARGE

### Beth Adams, MA, RN, NREMT-P

I am asking for your support in my bid to represent you as the professional member-at-large to the NAEMSP Board of Directors. I believe that the strength of an organization lies in the committed involvement of its members and feel that I have demonstrated my commitment to NAEMSP during the 10+ years of my membership.

I noticed that the membership renewal form I received yesterday lists my date of membership as August 1989. How time flies and how things have changed! At that time, professional members (then called "associate members") were required to submit an application form plus a CV and list two physician references who were members in good standing of NAEMSP for consideration for membership. In the intervening years, many things have changed within and outside of the organization, but among the things that haven't changed is that no other organization better represents the collaborative nature of emergency medical service education and delivery, and the membership roster still reads like the Who's Who in EMS.

The professional membership has been well-served and well-represented on the board of directors by Keith Neely since 1996, and it is my intention to continue in the tradition that he established, seeking to increase the involvement and participation of the professional members for the benefit of the organization. I have had the opportunity to serve the organization on the Education Committee (1992 - 1996), the Program Committee (1992 - present), and as co-chair of the EMS Education Committee (1996 - present). I served as Program Chair for the 1998 Annual Meeting, marking the first time a professional member served in this capacity. Additionally, I was NAEMSP's representative to the National Commission Against Drunk Driving from 1991 to 1996.

I am currently the ALS-CME Coordinator for EHS Programs at The George Washington University School of Medicine and Health Sciences. Additionally, I've served as an item writer for

the National Registry, collaborated on several EMS texts, presented at numerous conferences and worked on a variety of projects related to provider/instructor development, pediatrics, ethics, CQI, and customer service.

I am committed to promoting the continued growth and evolution of NAEMSP, the increased involvement of professional members, and continuance of NAEMSP's role as a key player in the implementation of the *EMS Agenda for the Future*, as well as other national/international initiatives. I would consider it a privilege and an honor to represent you.

## Jerry Overton, MPA

As a nominee for the professional member-at-large, I want to thank the Nominating Committee for this opportunity to serve NAEMSP. It is always a pleasure to serve the NAEMSP leadership and actively participate in the committees and meetings, and it would be an honor to become even more involved and serve as a member of the board of directors.

NAEMSP has made a tremendous impact on EMS. With its scientific approach, NAEMSP has objectively advanced the credibility and visibility of our role in the health care continuum. The leadership had the foresight to be inclusive of other professions involved in EMS, and the result is a solid foundation of members that can drive change. It is an association of which I am proud to be a member.

My involvement in EMS dates back to 1973 when I was responsible to a regional EMS agency for implementing U.S. Health, Education, and Welfare grant funds for EMS systems development. I then assumed a direct administrative role, becoming the Chief Executive of the Kansas City, Missouri, EMS system during a time of crisis. In 1991, after the collapse of the Richmond, Virginia system, I became its first Executive Director and have served in that capacity since. Both systems have earned international recognition for quality patient care, performance accountability, innovation and fiscal responsibility.

I believe in the humanitarianism of what we are about. I assist our local governments to help them understand and implement the different components of a quality EMS system. Through different funding agencies, I have volunteered my time to assist those in Central Asia, Russia, and Africa to develop programs that will provide aid to those in need.

It was the pursuit of quality patient care that led to my active participation in NAEMSP. For the past 10 years, I have been faculty for the NAEMSP National EMS Medical Directors Course and Practicum, teaching "System Design" to over 15 classes of students and have served as a resource to many current and future medical directors, providing assistance or answering questions regarding specific situations. In 1996-1997, I served as a member of the Steering Committee that developed the *EMS Agenda for the Future: Implementation Guide*. Currently, I am the professional member of the Writing Team for the "Medical Direction: National Standard Curriculum." I have also presented at the NAEMSP annual meetings.

EMS is at an extremely important juncture in its development. We are faced with the uncertainty of future funding and increasingly higher levels of expectations. Physicians and professionals must work collaboratively to insure that the gains we have made for our patients are not lost and that our future remains bright. NAEMSP can impact that future with its leadership position in EMS. As a professional who understands the dynamics involved, I will commit my time and resources to work with the others on the board to assist you, our membership, to prepare for the changes ahead. Thank you for your consideration. \*

# Wireless Enhanced 911 Building a Template in New York State

Dr. Kathleen Dunn, Project Medical Director,  
and Jay Scott, Project Director  
State University of New York (SUNY) Upstate Medical University,  
Syracuse, New York

Stakeholders involved in all aspects of emergency services gathered together in Syracuse, New York, June 6-7, 2000, to discuss development of a statewide wireless enhanced 911 system. E911 – the system that automatically identifies a caller's location and callback telephone number – is in place for wireline (regular) telephones across most of New York. What few people realize is that E911 does not work with wireless phones. This makes it difficult, if not impossible, to dispatch emergency services to wireless callers who don't know their location or who aren't able to convey that information. A young woman lost on a highway, a child witnessing an emergency, an elderly man disoriented following a head injury from a fall are cases that are frighteningly common.

Currently one-third of all calls to 911 are made from cell phones. There are 92 million cell phones now in use in the United States, with the number expected to grow to 235 million by 2005. At that point, experts believe that over half of all calls to 911 will be made from cell phones. In effect, the enhanced 911 infrastructure – the ability to automatically locate people placing an emergency call – is becoming less and less effective every day. This is a startling fact to the 46 percent of people who buy their cell phones for safety reasons.

New York has a unique opportunity to lead the nation in developing a model system for statewide wireless E911. The Department of Emergency Medicine at Upstate Medical University is partnering with the National Highway Traffic Safety Administration and the U.S. Department of Transportation's Intelligent Transportation System to help emergency service personnel and others accomplish this goal. Key stakeholders in the process include the New York State Police, the New York State Sheriff's Association, the Fire Association of the State of New York, the Department of Criminal Justice Services, the New York State Wireless Carriers Coalition, the Emergency Medical Services Bureau of the New York State Department of Health, emergency physicians and nurses, trauma surgeons, legislative leaders, transportation engineers, telecommunications experts and others.

Many of these groups have been working individually for years on various aspects of the wireless E911 problem. The stakeholders' meeting at Upstate Medical University marked the beginning of a larger coalition called the Emergency Call Locator Partnership. Their goal is to save lives by improving the timeliness and effectiveness of emergency services for victims of crime, injury, illness and fire. Although the technology for wireless E911 exists, the coalition identified a number of barriers that must be overcome before the technology can be put into place. These barriers include equipment upgrades, call routing and dispatch protocols, cost reimbursement mechanisms and privacy issues. The Emergency Call Locator Partnership will meet regularly to identify solutions to these and other challenges.

The National Highway Traffic Safety Administration awarded the Department of Emergency Medicine at Upstate Medical University a three-year \$975,000 grant to facilitate the development of New York's wireless E911 system. New York's model will serve as a template for other states' systems. If you would like more information about the New York State Emergency Call Locator Partnership and its activities, please call the Injury Control Center, Department of Emergency Medicine, Upstate Medical University, at 1-(800) 585-5130 or (315) 464-4365. \*

# Searching the Medical Literature: A Primer for EMS Personnel

Jean C. Blackwell, MLS\*, and Jane H. Brice MD, MPH\*\*

Searching the medical literature for articles related to emergency medical services (EMS) can prove to be a frustrating and time-consuming task. MEDLINE, produced by the National Library of Medicine (NLM), is the premier database for indexing the world's medical literature. Cumulative Index to Nursing & Allied Health Literature (CINAHL), published by CINAHL Information Systems, provides authoritative coverage of nursing and allied health disciplines, including emergency services. Both databases offer challenges to the inexperienced searcher due to their specialized vocabularies and complex search features. Knowing how to use the indexing terms and search options will allow you to take full advantage of these databases and find the information you need more efficiently. This article uses an illustrative example to demonstrate the basics of MEDLINE searching. It also presents selected resources for retrieving the full content of systematic reviews, medical texts, journal articles, practice guidelines and drug information.

## THE QUESTION

How do paramedics manage pain in the field?

## FINDING ANSWERS

### MEDLINE

MEDLINE is best searched using NLM's controlled vocabulary Medical Subject Headings (*MeSH*). *MeSH* terminology provides a consistent way to retrieve information that may use different words for the same concepts. For example, an author may use various terms to refer to cancer (cancer, tumor, tumour, neoplasm), but searching on the *MeSH* term *Neoplasms* gets all of these. *MeSH* terms are organized in a hierarchical structure, or tree, so that broad concepts may be expanded (exploded – exp) to include more specific, or narrower, terms. You can also search by author name, title word, keyword, journal name, phrase or any combination of these. The result is a list of citations (including authors, title, source and often an abstract) to journal articles. Indexing 4,300 journals in more than 30 languages from 1966 to the present, MEDLINE's massiveness can be daunting to the occasional user who needs only a few good articles as quickly as possible.

Example 1.

MEDLINE 1997-2000	Results
1 Exp Pain	19,247
2 Exp Emergency treatment	7,110
3 Emergency medical technicians	227
4 Exp Emergency medical services	5,849
5 1 and (2 or 3 or 4)	427
6 Pre-hospital or prehospital or paramedics or ems	1,255
7 5 and 6	26
8 Limit 7 to human and English language	21

In the example above, we are trying to get articles about two different topics: pain and EMS. We then want to combine

the two topics to find articles that are relevant to answer our question. In MEDLINE, EMS cannot be covered by a single *MeSH* term. The most useful terms are: 1) emergency treatment, 2) emergency medical technicians, and 3) emergency medical services.

Search strategy explained:

1. The *MeSH* term *pain* is exploded (exp) to ensure the inclusion of all types of pain. If it were not exploded, the results would have been 7,976 articles on pain in general, instead of the 19,247 articles that include pain and narrower terms such as *abdominal pain*, *back pain*, *chest pain*, *headache*, *neck pain*, and so forth. If you want just *chest pain*, use that term instead.
2. Likewise, exploding emergency treatment expands the search to include the narrower terms *first aid*, *resuscitation*, and *transportation of patients*.
3. There is more than one term needed to cover EMS, so *emergency medical technicians* is also searched. It needs no exploding because it has no more specific terms.
4. *Emergency medical services* is also relevant to EMS, and exploding includes *emergency medical service communication systems*; *emergency service*, *hospital*; *emergency services*, *psychiatric*; *poison control centers*; and *triage*.
5. *Pain* (1) is combined with the three terms needed to cover EMS (2 or 3 or 4).
6. Because *emergency medical services* also includes hospital emergency service, adding keywords (prehospital or prehospital or paramedics or EMS) increases the chances of finding articles specific to EMS. A keyword search finds any occurrence of the word in the title or abstract or subject headings, whereas searching by *MeSH* term retrieves all articles on a topic, no matter how authors express it.
7. Searches 5 and 6 are combined to reduce the number of articles (427) to a more manageable set specific to EMS.
8. Search 7 is limited to human and English, yielding 21 articles.

MEDLINE is available through several providers: free from NLM's PubMed and Internet Grateful Med, HealthGate, Medscape and others; and for a fee from Ovid, SilverPlatter, OCLC FirstSearch and others. The search interface looks different with each of these providers, but the basics of searching the MEDLINE database are the same.

MEDLINE Search Basics:

- When performing a search, it is best to enter one subject at a time.
- Explode if you are offered that option. Some search interfaces do this automatically and others do not. This feature expands the subject term to pick up more specific, or narrower, terms. A keyword cannot be exploded.
- Ask for all subheadings if that option is available. Exceptions are in cases where a specific subheading such as *diagnosis* is precisely what you need.

## Searching the Medical Literature

- Combine individual search statements with AND if you want the overlap of the topics (AND is used to narrow searches); combine with OR if you want any of the topics to be included (OR increases the results).
- Limit to human and English.
- Limit to reviews if you need general knowledge articles.
- Limit to meta-analysis for comparisons of independent research studies.
- Limit to practice guideline if you need practice protocols.  
(Note that all providers do not offer the same array of options.)

### CINAHL

The Cumulative Index to Nursing & Allied Health Literature (CINAHL) indexes *JEMS: Journal of Emergency Medical Services, Prehospital & Disaster Medicine, Pre-Hospital Immediate Care* and others of potential interest that are not indexed in MEDLINE. The basic search strategies are the same as MEDLINE's, but the vocabulary is somewhat different, so use the terms prehospital care or emergency medical technicians to get articles specific to EMS. As in MEDLINE, you may also find it useful to search for the keywords pre-hospital, prehospital, paramedics, out-of-hospital or EMS.

### FULL TEXT RESOURCES

Databases such as MEDLINE and CINAHL provide only citations and abstracts in most cases. The articles have to be ordered for a fee or fetched from a medical library. There are other resources that provide full text information relevant to EMS personnel and educators.

The **Cochrane Library** (<http://www.cochrane.org/cochrane/cdsr.htm>) is a for-fee electronic publication designed to supply high quality evidence to support medical decisions. The abstracts from the Cochrane Database of Systematic Reviews are available without charge and can be browsed or searched ([www.update-software.com/abstracts](http://www.update-software.com/abstracts)). Although there are few systematic reviews in pre-hospital emergency care, Cochrane Controlled Clinical Trials Register includes a number of generally relevant trials.

**Emergency Medicine**, an eMedicine textbook on the Web ([www.emedicine.com](http://www.emedicine.com)), is one of a series of 15 electronic, peer-reviewed textbooks written by a panel of authors and editors, and it is available free of charge to anyone with Internet access. Advantages of the online textbook are easy accessibility to reliable, current information and the capacity to supplement traditional text with sound, graphics and video.

**MD Consult** ([www.mdconsult.com](http://www.mdconsult.com)) is a subscription product offering access to the full text of more than 30 medical texts, including "Ellenhorn's Medical Toxicology," Roberts: "Clinical Procedures in Emergency Medicine," and Rosen: "Emergency Medicine: Concepts and Clinical Practice." It also includes complete articles from over 50 medical journals, including *American Journal of Emergency Medicine, Annals of Emergency Medicine, and Emergency Medicine Clinics of North America*.

**National Guideline Clearinghouse** ([www.guideline.gov](http://www.guideline.gov)) is a free database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ), in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP). It can be searched by disease/condition, treatment/intervention or issuing organization. Many of the guidelines are presented in full, while others have extensive summaries.

**Clinical Pharmacology 2000** ([www.cp.gsm.com](http://www.cp.gsm.com)) is a free drug information resource, although registration is required. It provides comprehensive information on prescription, OTC and investigational drugs, as well as herbal and nutraceutical products. It also covers drug interactions and drug comparisons and has drug photographs and product identification.

### GENERAL TIPS

No matter what resource you are searching, keep these things in mind:

- Start with a clear definition of the question and identify the key terms to describe it. One way to discover the best terms is by looking at the subject headings in a particularly relevant article.
- Consider whether the information you need is more likely to be found in a journal article, textbook, drug guide or some other resource.
- Make use of the HELP or SEARCH HINTS feature that is available in all electronic resources – it will save you time and increase the chances of a successful search.
- Be cautious in concluding there is no research. Perhaps you are not asking the right question or not asking it in the right way.
- Enlist the help of a librarian if you run into trouble.

\* Reference Librarian, Health Sciences Library, University of North Carolina, CB# 7585, Chapel Hill, NC 27599-7585.  
\*\* Assistant Professor, Department of Emergency Medicine, University of North Carolina, CB# 7594, Chapel Hill, NC 27599-7594. \*

## January 2000 Conference Audiotapes Available

Audiotapes are available from the NAEMSP January 2000 Annual Conference. Purchase the complete set of tapes or individual tapes for your own personal library or to share with your colleagues. Tapes can be purchased from West Coast Audio Taping. Call for an order form at (800) 825-8899. Tapes are also available from earlier conferences. For more information, contact the NAEMSP Executive Office at (913) 492-5858, ext. 448.

# News From the Executive Office

Dede Gish-Panjada, Executive Director, and Beth Panther, Association Manager

## 2000 Membership Drive

Continued from last year, we are again conducting a membership drive for the year 2000. Each time a current member recommends NAEMSP to a colleague who then becomes a member, the current member will have their name placed in a drawing to be held during the January 2001 Annual Meeting. For example, if you refer three new members, your name will be entered in the drawing three times. The winner will receive his/her choice of either complimentary membership for one year (up to a \$250 value) or complimentary registration to the annual meeting (up to a \$455 value). Just be sure the individual you refer includes your name on his/her membership application so we can enter your name in the contest. Help your professional organization to grow by encouraging others to join while you benefit at the same time!

## 2001 Annual Conference: January 18-20, Sanibel Harbour Resort, Florida

This issue of NAEMSP News contains an insert with the updated preliminary education program for the January 2001 Annual Meeting. Our Program Chair, Dr. Tom Blackwell, and the Program Committee have been hard at work putting this cutting-edge education program together. Please remember that this is a preliminary program and is subject to change. As the program evolves, it will continue to be updated in future issues and on our Web site. If you have any questions or comments about the program, contact Dr. Blackwell at [tblackwell@carolinas.org](mailto:tblackwell@carolinas.org) or the NAEMSP Executive Office at (913) 492-5858, ext. 448.

## Web Site Update

Premium Web, our Internet Service Provider, has designed a new look for our Web site, which should be implemented by the time you receive this newsletter. With assistance from Technology Committee Chair Dr. Ed Michelson and committee member Dr. Steve Weiss, we are very excited to have a new, professional Web site to better serve our members. The "members only" area is continuing to be developed, and e-commerce will be the next

major feature added. *At this time, the password to access the current "members only" area is **Sanibel** (with a capital S and the rest of the letters in lower case). However, the only information currently in this area is copies of the newsletters. You can access all the other areas of the site without using a password.* When the new "members only" area is complete, you will need an individual password to access the area. This will be your membership ID number. (By now you should have received your membership ID card in the mail). Be sure to keep this handy for when the "members only" area becomes accessible only with your membership ID number.

E-commerce will allow our members to renew their membership, register for the conference, and order merchandise online. We hope this feature will provide a more convenient and efficient way for you to register and pay for these activities.

## Shop Online and Support NAEMSP

The NAEMSP Board of Directors recently approved joining the [amazon.com](http://amazon.com) Association program, the leading-selling program on the Internet with over 400,000 members. Providing a link from our Web site to [amazon.com](http://amazon.com) will help to serve our members by helping you find EMS-related publications (or books, tapes, etc.) and help our association at the same time. For every visitor who links to [amazon.com](http://amazon.com) from NAEMSP's site and makes a purchase, [amazon.com](http://amazon.com) will donate a percentage to NAEMSP to help support EMS. We plan to develop a "Recommended Readings" section on our Web site to help new and veteran EMS personnel alike complete their EMS reference library.

The board also approved providing a link from our Web site to the Audio-Digest Foundation, which provides physicians and other health care professionals with Category 1 continuing medical education (CME) and continuing education (CE) credits on audiotapes. Again, when visitors link from our site to the Audio-Digest Foundation site and make a purchase, a percentage of the sale will go to NAEMSP. Please consider these two methods of support to your professional organization when shopping online. \*

# UPDATE GRANTS

Debra Perina, MD, Grant Co-Principal Investigator and Director of Prehospital Care Division, University of Virginia, Department of Emergency Medicine, Charlottesville, Virginia

## Medical Direction: National Standard Curriculum

A few years ago, the National Highway Traffic Safety Administration (NHTSA) recognized the need to develop a national standard curriculum for medical direction that could be made available for all states to utilize, similar to that of the EMT-B and paramedic curricula. NAEMSP, along with the American College of Emergency Physicians (ACEP), were recipients of the NHTSA grant to develop such a document. Dr. Jon Krohmer and I were designated principal and co-principal investigators for this project. Together, along with the National Writing Team, we have developed several drafts of a model curriculum. These drafts have been available for review and comment on the NAEMSP Web site. We greatly appreciate all the help and suggestions many of you have given us for curriculum inclusions. We have received many requests for the curriculum, as well as a time frame for release of the final document. The good news is that the curriculum is nearing completion!

Two more pilot courses were held in Concord, New Hampshire, on May 31 and June 1, 2000. Physicians, EMS administrators and EMS educators from several states and Canada were in attendance. To date, the course presentations have been well received, and the feedback supportive and positive. Several suggestions obtained from the most recent pilot presentations have been incorporated into the current draft of the curriculum document. The National Review Team will meet in August to review these proposed changes. Following this meeting, the final changes will be incorporated and the finished curriculum will be made available for distribution by NHTSA. On behalf of Jon and myself, we would like to thank everyone who helped make this curriculum a reality. \*

# Mass Gathering Medical Care Guidelines: Now Available

## CALIFORNIA CORNER

**John F. Brown, MD, President,**  
**EMS Medical Director's**  
**Association of California**

Attention EMS medical directors and EMS professionals involved in medical care delivery at large events! The NAEMSP position paper entitled *Mass Gathering Medical Care* will be published in the upcoming (October-December 2000) issue of *Prehospital Emergency Care*. This official statement is accompanied by a working document entitled "Mass Gathering Medical Care: The Medical Director's Checklist," which is now available through the NAEMSP Executive Office.

The "Checklist" is a comprehensive guide to planning for medical coverage at a mass gathering event. Each of the 15 components of mass gathering medicine identified in the position paper is accompanied by a brief discussion of its importance and a list of essential and desirable actions to be addressed through the overall medical action plan. Though the guidelines recognize that a medical director will tailor the plan to the unique aspects of the specific event, the medical director or the individual writing a mass gathering medical action plan will find the "Checklist" an extremely useful reference to ensure that critical issues have been addressed and incorporated into this plan. Also included is a suggested equipment and pharmaceutical list for deployment at fixed medical aid stations. Portions of this document have already been used to assist in planning for events connected to the Republican National Convention in Philadelphia and for development of citywide mass gathering regulations in Columbus, Ohio. For more information about "Mass Gathering Medical Care: The Medical Director's Checklist," contact the NAEMSP Executive Office at (913) 492-5858, ext. 448. An order form is provided below.

**WMD** – Weapons of Mass Destruction ... an acronym that strikes fear into the heart of many a medical director (and most other public safety agency personnel). As a high profile (aka "high target") state, California is struggling with the role of medical direction and medical therapy/scope of practice in the treatment of victims of a release of chemical, biological, radioactive and large conventional explosive devices.

California currently has four cities in the first group of local jurisdictions targeted to receive seed grant funding from the Department of Health and Human Services' Metropolitan Medical Response System (MMRS) Program (Los Angeles, San Diego, San Francisco and San Jose) and three cities in the second group (Oakland, Sacramento and Long Beach), with more to follow. Each MMRS utilizes a different approach to the medical direction of "sentinel" event WMD releases (such as the use of a chemical device where the initiation of the attack is recognized), with base station medical consultation being the immediate response and a scene MD provided for prolonged events. Medical direction of non-sentinel event attacks (such as a biological agent) is still under development but closely parallels the role of the County Health Officer in controlling outbreaks of emerging infectious diseases.

The scope of practice for paramedics in California currently includes such potentially effective medications as atropine, valium and beta-2 agonists, but several jurisdictions have pursued the approval of 2-PAM for nerve agent poisonings and sodium thiosulfate for cyanide releases. These are approved through the optional scope of practice mechanism by the state EMS Authority, but to date have been done on a case-by-case basis. A difficulty with this approach has been the lack of relevant field experience and research to show the usefulness of these therapies by field personnel. Dr. Rick Dart and a group led by the Rocky Mountain Poison Center are developing a package of standardized protocols to deal with these agents that addresses the issues of skill level of the field personnel, the circumstances under which the therapies may be initiated (e.g., level A suit vs. normal treatment environment) and the different circumstances of treating an isolated case vs. a multi-casualty incident. You may want to visit the National Disaster Medical System (NDMS) Web site ([www.ndms.dhhs.gov](http://www.ndms.dhhs.gov)) to obtain further information.

In the meantime, we focus our attention on readiness exercises and improving the response to biological incidents in partnership with our public health colleagues. \*



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### Mass Gathering Medical Care: The Medical Director's Checklist: A Product of the NAEMSP Standards & Clinical Practice Committee

<u>Authors</u>	<u>Qty.</u>		<u>Cost</u>
David Jaslow, MD, MPH	___	<input type="checkbox"/> NAEMSP Member	\$15 ea. \$ _____
Arthur Yancey II, MD, MPH	___	<input type="checkbox"/> Nonmember	\$30 ea. \$ _____
Andrew Milsten, MD		Shipping & Handling	5.00 _____
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To order *Mass Gathering Medical Care: The Medical Director's Checklist*, please fill out the following information and return it to the NAEMSP Executive Office at the above address.

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

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# EMS Calendar . . . . .

**January 18-20, 2001:** NAEMSP Annual Meeting. Location: Sanibel Harbour Resort & Spa, Fort Myers, Florida. Contact: (913) 492-5858, ext. 448.

**October 5, 2000:** Biological and Chemical Terrorism: Are you Ready? Location: Children's Hospital of Michigan, Detroit. Contact: (313) 745-5458.

**October 15-19, 2000:** PECEMS 2000: 5th Pan-European Conference on Emergency Medical Systems; PECEMMS Foundation. Location: Sarajevo, Bosnia i Herzegovina (BIH) Contact: Eelco Dykstra, MD at (011) 31 55 360-4490 (Neth); or e-mail [e.dykstra@wxs.nl](mailto:e.dykstra@wxs.nl).

**October 16-19, 2000:** FIRST DUE: Fire and Rescue Conference and Exposition, JEMS. Location: Las Vegas, Nevada. Contact: (800) 266-5367.

**October 17-22, 2000:** National Association of State EMS Directors (NAEMSD) Annual Meeting. Location: Catamaran Resort Hotel, San Diego, California. Contact: (703) 533-0251.

**October 23-26, 2000:** American College of Emergency Physicians (ACEP) Scientific Assembly. Location: Philadelphia, Pennsylvania. Contact: (800) 477-ACEP.

**November 7-11, 2000:** Outlook 2000, National Association of EMTs Conference & Exposition. Location: Reno, Nevada. Contact: (800) 64-NAEMT.

**November 8-12, 2000:** American Ambulance Association Annual Conference and Trade Show. Location: Tampa, Florida. Contact: (800) 523-4447.

**November 9-11, 2000:** International Trauma Conference 2000, BTLS International. Location: Westminster, Colorado. Contact: (800) 495-BTLS.

**January 17-21, 2001:** Emergency Response Update Conference and Exposition, National Safety Council. Location: Orlando, Florida. Contact: (800) 621-6244, ext. 2106.

**April 9-11, 2001:** Fire-Rescue Med 2001: Management Issues for Fire Service-based EMS, Int'l Assn of Fire Chiefs. Location: Las Vegas, Nevada. Contact: (703) 273-0911.

**June 6-9, 2001:** Effective Strategies for Tomorrow's EMS Systems, Int'l Assn of Fire Fighters. Location: Minneapolis, Minnesota. Contact: (202) 737-8484.

The Department of Emergency Medicine at the University of Pittsburgh School of Medicine is seeking a full-time EMS-Communications Physician for a variety of innovative new programs. Duties will include prehospital medical command, medical support for commercial airlines, telemedicine and medical command to the nation's busiest air medicine program. Emergency Department clinical opportunities are optional. Candidates must be residency trained and board certified/eligible in Emergency Medicine. If interested, please send CV to:

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Professor and Chairman  
Department of Emergency Medicine  
230 McKee Place  
Suite 500  
Pittsburgh, PA 15213

*The deadline for article and advertisement submissions for the November 2000 issue of [NAEMSP News](#) is September 27, 2000.*



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# NAEMSP 2001 Annual Meeting

Sanibel Harbour Resort & Spa ■ Fort Myers, Florida ■ January 18-20, 2001

The following is the preliminary program for NAEMSP's January 2001 Annual Meeting. Please note that topics and times are subject to change. The program will continue to be published in this newsletter as it evolves. You can also watch our Web site at [www.naemsp.org](http://www.naemsp.org) for updates and more information. The preliminary program will be mailed to all NAEMSP members in early October.

Don't miss this opportunity to participate in these exceptional educational offerings and to network and socialize with your colleagues at this outstanding location. Situated on its own private peninsula, the Sanibel Harbour Resort & Spa boasts three swimming pools, water sports, tennis and a world-class spa amid 80 acres of unspoiled natural beauty. The resort is located just 19 miles or about 25 minutes from SW Florida International Airport in Ft. Myers. Reservations can be made at (800) 767-777 or (941) 466-4000. Be sure to mention your affiliation with NAEMSP to receive our special group rate of \$184 single/double. You must be attending NAEMSP's annual meeting to receive these discounted room rates. Visit the Sanibel Harbour Resort & Spa's Web site at [www.sanibel-resort.com](http://www.sanibel-resort.com).

Various pre- and post-conference workshops will also be held, including the NAEMSP National EMS Medical Directors Course, the leading EMS medical director educational course.

## Saturday, January 13

1:00 p.m. – 6:00 p.m. NAEMSP National EMS Medical Directors Course

## Sunday, January 14 & Monday, January 15

8:00 a.m. – 6:00 p.m. NAEMSP National EMS Medical Directors Course

## Tuesday, January 16

8:00 a.m. – 1:00 p.m. NAEMSP National EMS Medical Directors Course

8:00 a.m. – 9:00 a.m. NAEMSP Finance Committee Meeting

9:00 a.m. – 5:00 p.m. NAEMSP Board of Directors Meeting

## Wednesday, January 17

### Pre-Conference Activities

8:00 a.m. – 1:00 p.m. Medicolegal Workshop, *Spencer Hall, MD, JD; Ann Maggiore, JD*

8:00 a.m. – 5:00 p.m. NAEMSP Research Workshop, *David Cone, MD; Robert O'Connor, MD; Michael Sayre, MD; Lynn White, MS, et. al.*

8:00 a.m. – 5:00 p.m. CONTOMS (or equivalent) Medical Directors Course, *Joseph Heck, DO; Joshua Vayer, BA*

8:00 a.m. – 5:00 p.m. Hazardous Materials/Decontamination Field Exercise (*tentative, off-site*)

5:00 p.m. – 7:00 p.m. Committee Meetings – see preliminary schedule on the back of this flyer

7:30 p.m. – 10:00 p.m. New Member Reception and Softball Game (*tentative, off-site*)

## Thursday, January 18

### Conference Sessions

7:00 a.m. – 9:00 a.m. Committee Meetings – see preliminary schedule on the back of this flyer

9:00 a.m. – 10:00 a.m. Introduction and Welcome, President's Address and NAEMSP Business Meeting

10:00 a.m. – 11:00 a.m. C.J. Shanaberger Memorial Lecture and Keynote Address, *Ricardo Martinez, MD, senior vice president of Health Affairs at Healthcon/WebMD and former director of the EMS Division, National Highway Traffic Safety Administration (NHTSA)*

11:00 a.m. – 11:15 a.m. Refreshment Break

11:15 a.m. – 12:15 p.m. Research Presentations #1

12:15 p.m. – 1:30 p.m. Lunch on own or International Luncheon (*additional fee applies*)

12:15 p.m. – 1:30 p.m. *Prehospital Emergency Care* Luncheon and Editorial Board Meeting (by invitation only)

### Seminar on Medical Direction

1:30 p.m. – 2:00 p.m. Attributes of the Successful Medical Director, *Bob Bailey, MS*

2:00 p.m. – 2:45 p.m. Medicolegal Issues for the EMS Medical Director, *Spencer Hall, MD, JD*

2:45 p.m. – 3:00 p.m. Refreshment Break

3:00 p.m. – 3:45 p.m. Medical Direction Practices, *Edward Racht, MD*

3:45 p.m. – 4:00 p.m. Medical Direction Panel Discussion

4:00 p.m. – 5:00 p.m. Standards and Clinical Practice Committee Position Development Forum #1: Prehospital Pain Management, *Hector Alonso-Serra, MD*

5:00 p.m. – 6:00 p.m. Moderated Poster Session #1

6:00 p.m. – 8:00 p.m. Welcome Reception

## Friday, January 19

7:00 a.m. – 8:00 a.m. Committee Meetings – see preliminary schedule on the back of this flyer

8:00 a.m. – 9:00 a.m. Research Presentations #2

9:00 a.m. – 10:00 a.m. Research Project: Prehospital Treatment of Status Epilepticus, *Megan Corry, MA, EMT-P*

9:00 a.m. – 12:00 noon Computers for Medical Professionals I: Computer Data Management, *Edward A. Michelson, MD; Steven Weiss, MD (additional fee applies)*

10:00 a.m. – 10:15 a.m. Break

10:15 a.m. – 11:45 a.m. EMS System Showcase, Moderator: *Thomas Blackwell, MD*

10:15 a.m. – 11:00 a.m. Rural: Red River Project, *Ron Burnham*

11:00 a.m. – 11:45 a.m. Urban: Seattle, Washington, *Michael Copass, MD*

11:45 a.m. – 12:30 p.m. Standards and Clinical Practice Committee Position Development Forum #2: Management of Prehospital Traumatic Arrest, *Robert Domeier, MD*

12:30 p.m. – 1:30 p.m. Lunch on own or Diversity Luncheon.  
Speaker: *Carrye B. Brown, U.S. Fire Administrator, Federal Emergency Management Agency (FEMA); Pauline Campbell, Director of the Office of Equal Rights, Federal Emergency Management Agency (FEMA), (additional fee applies)*

1:30 p.m. – 2:30 p.m. Medical Response to Hurricane Floyd,  
*Ritu Sahni, MD; Juan March, MD*

1:30 p.m. – 4:30 p.m. Computers for Medical Professionals II:  
Internet and Web Page Design, *Edward A. Michelson, MD; Steven Weiss, MD (additional fee applies)*

*This afternoon is free to enjoy this beautiful location! Be sure to return for the moderated poster session beginning at 5:00 p.m. and the themed social event following at 6:00 p.m.*

5:00 p.m. – 6:00 p.m. Moderated Poster Session #2

6:00 p.m. – 8:00 p.m. Themed Social Event, supported by Wyeth-Ayerst Laboratories

## Saturday, January 20

7:00 a.m. – 9:00 a.m. Committee Meetings – see preliminary schedule below

9:00 a.m. – 10:00 a.m. Research Presentations #3

### Track I Advances in Prehospital Airway Support 10:00 a.m. – 12:30 p.m.

10:00 a.m. – 10:45 a.m. Non-invasive Ventilatory Support in the Field: How Realistic?, *Charles V. Pollack Jr., MA, MD, FACEP*

10:45 a.m. – 11:00 a.m. Refreshment Break

11:00 a.m. – 11:45 a.m. Alternative Airway Adjuncts, *Michael F. Murphy, MD, FRCPC*

11:45 a.m. – 12:30 p.m. Rapid Sequence Intubation Programs – Review and Implementation Strategies, *Douglas J. Floccare, MD, MPH, FACEP; Stephen Thomas, MD*

9:00 a.m. – 11:30 a.m.

### Track II Preparedness Initiatives for Urban Terrorism

9:00 a.m. – 9:45 a.m. Hospital Preparedness for Hazardous Materials Multiple Casualty Incident, *John Hoyle, Capt., USPHS*

9:45 a.m. – 10:45 a.m. Chemical and Biological Agent Monitoring and Detection, *David Franz, DVM*

10:45 a.m. – 11:00 a.m. Refreshment Break

11:00 a.m. – 11:30 p.m. Response System Designs, *Guillermo Pierluisi, MD, MPH*

11:30 a.m. – 12:30 p.m. Research Presentations #4

12:30 p.m. – 1:30 p.m. Awards Luncheon

1:30 p.m. – 2:30 p.m.

### Track I Prehospital Education

1:30 p.m. – 2:30 p.m. Principals of Competency-Based Prehospital Education, *Judith Ruple, PhD, RN, NREMT-P*

2:30 p.m. – 3:30 p.m. Alternative Continuing Education Delivery Methodology, *Linda Honeycutt, EMT-P*

3:30 p.m. – 3:45 p.m. Refreshment Break

3:45 p.m. – 4:30 p.m. EMS Education for Resident Physicians, *Debra Perina, MD*

4:30 p.m. – 5:00 p.m. Challenges in Pediatric Prehospital Education, *George L. Foltin, MD, FAAP, FACEP*

### Track II Prehospital Equipment Evaluation

1:30 p.m. – 2:30 p.m. Innovations in Prehospital Data Collection, *Eric Davis, MD*

2:30 p.m. – 3:30 p.m. Hemodynamic and Other Physiologic Monitors, *Brian Zachariah, MD*

3:30 p.m. – 3:45 p.m. Refreshment Break

3:45 p.m. – 4:30 p.m. Ambulance Designs and Safety, *Steve Forrey*

4:30 p.m. – 5:00 p.m. Prehospital Equipment Evaluation Panel Discussion

## Sunday, January 21

8:00 a.m. – 11:00 a.m. President's Council Meeting

8:00 a.m. – 5:00 p.m. Incident Command System (ICS) Course, *John Sinclair, EMT-P*

11:00 a.m. – 3:00 p.m. Board of Directors Meeting

## Preliminary Committee Meeting Schedule

*Committee meeting times are subject to change. All conference attendees are welcome and encouraged to attend Committee meetings.*

### Wednesday, January 17

5:00 p.m. – 7:00 p.m. Legislative Task Force (*Drs. Hankins and Frascone*)

5:00 p.m. – 7:00 p.m. Standards & Clinical Practice Cmmt. (*Dr. Domeier*)

### Thursday, January 18

7:00 a.m. – 9:00 a.m. Diversity Task Force (*Dr. Moore*)

7:00 a.m. – 9:00 a.m. EMS Fellowship Directors (*Dr. Delbridge*)

7:00 a.m. – 9:00 a.m. Managed Care Task Force (*Mr. Neely*)

7:00 a.m. – 9:00 a.m. Operational EMS Sub-Task Forces (*Dr. Bogucki, et al.*)

7:00 a.m. – 9:00 a.m. Research Cmmt. (*Dr. Sayre*)

### Friday, January 19

7:30 a.m. – 9:00 a.m. Air Medical Task Force (*Dr. Thomson*)

7:30 a.m. – 9:00 a.m. Communications Cmmt. (*Dr. Hunt*)

7:30 a.m. – 9:00 a.m. EMS Administrators Task Force (*Ms. Smith*)

7:30 a.m. – 9:00 a.m. EMS Fellows & Fellowship Graduates Task Force (*Dr. Mitchell*)

7:30 a.m. – 9:00 a.m. Operational EMS Task Force (*full task force, Dr. Bogucki, et al.*)

7:30 a.m. – 9:00 a.m. Rural Affairs Task Force (*Dr. Mears*)

### Saturday, January 20

7:00 a.m. – 9:00 a.m. Education Cmmt. (*Dr. Dickinson*)

7:00 a.m. – 9:00 a.m. Membership Cmmt. (*Dr. Delbridge*)

7:00 a.m. – 9:00 a.m. Pediatrics Task Force (*Dr. Markenson*)

7:00 a.m. – 9:00 a.m. Program Cmmt. (*Dr. Blackwell*)

7:00 a.m. – 9:00 a.m. Public Relations Task Force (*Dr. Racht*)

7:00 a.m. – 9:00 a.m. Technology Task Force (*Dr. Michelson*)