

# The Emergency Medical Technician— Today

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LESS THAN seven years ago the majority of the nation's ambulance attendants were primarily "stretcher bearers," many of whom lacked even the most basic first aid training. In many communities the ambulance attendants were often the local funeral director and his assistant and the ambulance vehicle was a combination hearse. In other communities, volunteer firemen or volunteer ambulance corps transported the sick and injured.

Some of these people were trained, most were not. Many large cities relied on a combination of emergency service furnished by their police departments, fire departments, hospitals and private ambulance companies.

But things are changing. The implementation and acceptance of uniform standards for training and personnel are transforming these attendants into the nucleus of an army of Emergency Medical Technicians, ready to administer life-support and lifesaving measures to the ill and injured and transport them safely and properly to a medical facility.

Concern for improving at-the-scene emergency care is not new. Many organizations have taken steps to improve it over the years, including the Committee on Trauma of the American College of Surgeons, American Medical Association, and the Committee of Injuries of the American Academy of Orthopaedic Surgeons. But the greatest single impetus for change has been the passage of the Highway Safety Act of 1966. The U.S. Department of Transportation (DOT), charged with implementing this act, sponsored nationwide studies of ambulance services, initiated guidelines for developing emergency medical systems, and formulated the basic EMT training program.

The most significant changes that separate the EMT of today from his counterpart of yesterday are those related to vehicles, equipment and training.

Today's ambulance vehicle is defined as a vehicle for emergency care which provides a driver compartment and a patient compartment, designed to accommodate two litter patients so positioned that at least one patient can be given necessary life-support care during transport. It is a vehicle which carries equipment and supplies for optimal emergency care outside the vehicle and during transport, for light rescue, two-way radio communications, and so configured to safeguard the patient(s) and EMTs under hazardous conditions.

The ambulance is further defined as a vehicle to afford maximum safety and comfort to the patient, and to avoid aggravation of the patient's condition, exposure to complications, or any other threat to survival.

The majority of today's properly designed and configured ambulance vehicles are the van or modular type. We are seeing much less of the converted "automobile chassis" type of ambulance.

Equipment to be carried aboard the ambulance is listed as essential equipment as prepared by the Committee on Trauma of the American College of Surgeons, and accepted by the U.S. Department of Transportation.

However, the most important element aboard the ambulance is the properly trained EMT. With the growing number of training programs, progress in raising the level of ambulance attendants' skill and knowledge is being realized. Of the estimated 250,000 individuals engaged in the emergency ambulance services, approximately 65 percent have been trained and certified at the basic 81-hour EMT-A level.

The emergency ambulance service is a vital part of the overall emergency medical care system. As such, it must be considered a professional service that is due recognition and status similar to that of other allied health professions.

Even though there are a number of organizations whose membership consists of individuals engaged in the ambulance service, there has not been one single national accreditation organization which would attest to the proficiency of ambulance personnel. Individuals engaged in other allied health professions, such as X-ray and laboratory technicians, physical, occupational, and inhalation therapists, have for years been certified by their respective national registry, thereby attesting to their competency through uniform training and qualifying examinations.

Accepting the recommendation of the President's Committee on Highway Safety that there be a national accreditation agency to establish standards, and realizing that a national registry was essential for improved ambulance services, the Commission on Emergency Medical Services of the American Medical Association, chaired by I.E. Hendryson, MD, appointed a task force to study the feasibility of a registry for emergency medical technicians.

The task force, chaired by Oscar P. Hampton, Jr., MD, initially met on January 21, 1970, with representatives

of the various organizations involved in ambulance services. The participants at this meeting indicated the industry's concern for proper recognition, professional status, and uniform standards for personnel and training.

On June 4, 1970 at the AMA headquarters in Chicago, Illinois, the National Registry of Emergency Medical Technicians was born. It was on that date that the task force dissolved into the first board of directors meeting. Officers were elected, the constitution and by-laws were drawn and the examination committee, chaired by J.D. Farrington, MD, was appointed.

The registry administered the first examinations on October 29-30th, 1971, to 1,520 EMTs at 50 sites throughout the United States.

To date (as of May 25, 1976) the registry has received, accepted, and processed in excess of 80,000 applications representing EMTs from all 50 states, the military and a few from Canada. Examinations have been administered to qualified military medical corpsmen in Japan, Okinawa, Guam, Republic of China, Germany, England, Turkey, Italy, and Crete, plus on board the USS Coral Sea in the Pacific and the USS Albany in the Mediterranean.

The initial examination was less than optimal. As such, the examination was immediately revised to eliminate ambiguity, and increase reliability. Examinations are monitored by way of a total computerized "item analysis" and new or revised exams are issued periodically. Currently the registry has a bank of over 3,000 questions from which new examinations can be developed.

The current written examination is documented as being a most reliable instrument of measurement. To assist the examinees in identifying relative strengths and weaknesses, they are provided with a computerized listing of the subtest scores. All states extending mutual cooperation with the registry are also provided with computer print-outs listing subtest scores and additional demographic data, thereby permitting the state EMS staff an opportunity to correlate subtest scores and possibly identify weaknesses in local training programs and/or instructors.

Although the registry has issued guidelines for the administration of the practical examination, it has for the most part accepted the state practical exam, which in most cases equals or exceeds the registry guidelines. However, in evaluation of most practical exams

can be summarized by stating they are nothing short of a "can of worms". The reliability of any practical exam is totally dependent on the local examiners regardless of the presented criteria or guidelines.

Recognizing that the registry is one of the few, if not the only, allied health registries that require a "hands-on" practical exam, we could easily state that anything is better than nothing. That would in the vernacular of today's young people, be a cop-out, and the Registry of EMTs does not intend to cop-out on anything.

Being cognizant of the problems related to the measurement of performance skills (practical examinations) the registry has, in cooperation with the University of Southern California, (USC) developed the necessary production outlines for an audio/visual package to prepare the examiners in the administration of a uniform, objective, practical exam. This project is so unique that the U.S. Department of Health, Education, and Welfare has awarded the registry an unsolicited contract to finance the development of this total audio/visual package. The details of this project have been completed and "shooting" took place in February this-year at the School of Medicine. Upon completion and acceptance of this project, the registry intends to distribute a copy of the audio/visual package loan free to all state EMT teaching agencies extending mutual cooperation with the registry.

The registry has been active in studying the paramedic concept. In April of 1974, the registry called a national meeting of individuals involved in the development and implementation of paramedical services. The purpose of the meeting was to come up with a consensus relative to the required level of skills and knowledge, a proposed modular curriculum, and behavioral objectives.

A special committee was appointed from the initial group who developed the necessary list of skills and knowledge, guidelines for a modular curriculum, etc. This material was turned over to the DOT who in turn forwarded it to the University of Pittsburgh who was selected by DOT to develop the total EMT-Paramedic training package.

Appropriate examinations both written and practical are being developed for national registration as an EMT-Paramedic. The training and examination committee is currently working on this task with completion due simultaneously with the training package.

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