TOUGH

Learning to Seize

By John M. Becknell

Editor's Note:
This article is excerpted from the new JEMS *book by John Becknell,* Medic Life: Creating Success in EMS.

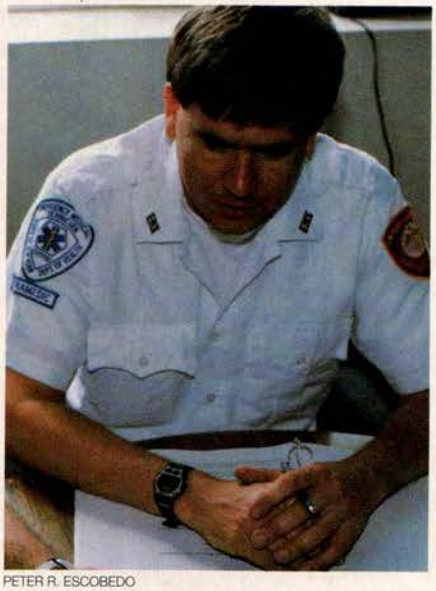
IT'S AFTERNOON, AND THE SHIFT has been slow. During the morning, you picked up a confused elderly lady with a high temperature from a nursing home. Your partner attended, and now it's your turn.

While waiting for the next call, you read a letter from your sister. She is bragging about your niece and how well she's doing in school (she's one of your favorites). You smile, thinking about her sparkling brown eyes and how she always hugs you when you walk in the door.

Then the pager sounds.

"One down at Jefferson Elementary," the dispatcher rattles off. "Code 3."

You never run to the ambulance, but something in your gut tells you this call is urgent. Your partner feels it too, and he has the engine running as you climb in. Trying to act nonchalant over the sound of the siren, your partner says, "Probably just a seizure."



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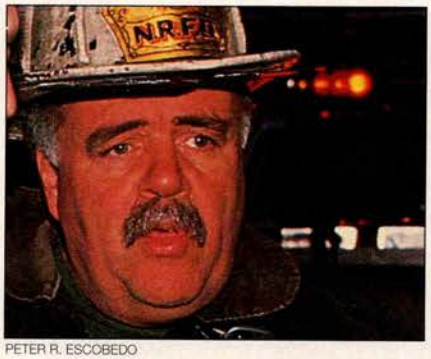

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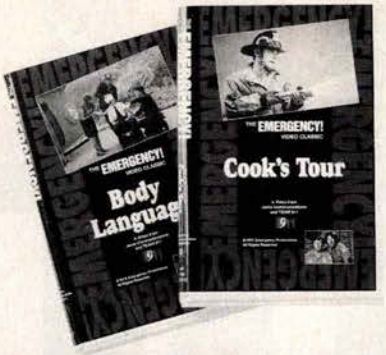

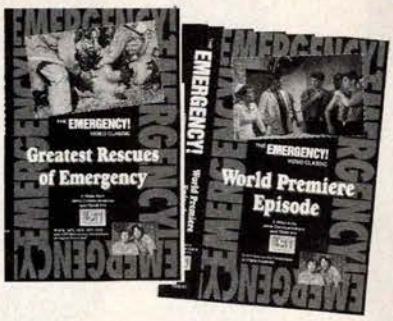

VOLUME I

k's Tour—Gage and DeSoto deliver a baby despite the father's est, and revive an electrical shock victim. DeSoto frets over his bad tation as a cook for the crew.

icity Hound—A young boy is rescued from a storm drain, mean- another station's paramedic is hogging the limelight.

rs—The collapse of a star quarterback is followed by rescue of a boy a hollow tree, with response time lengthened by drivers who refuse ld to emergency vehicles.

ee—A former military medic assigned to Gage and DeSoto for field ship defies medical control.

Bite—Gage is bitten by a rattler, and later transports a victim to a al where they've never heard of paramedics.

Language—A teenager eats daffodil bulbs, a cropduster is rescued his wrecked plane, and two accident victims fall in love.

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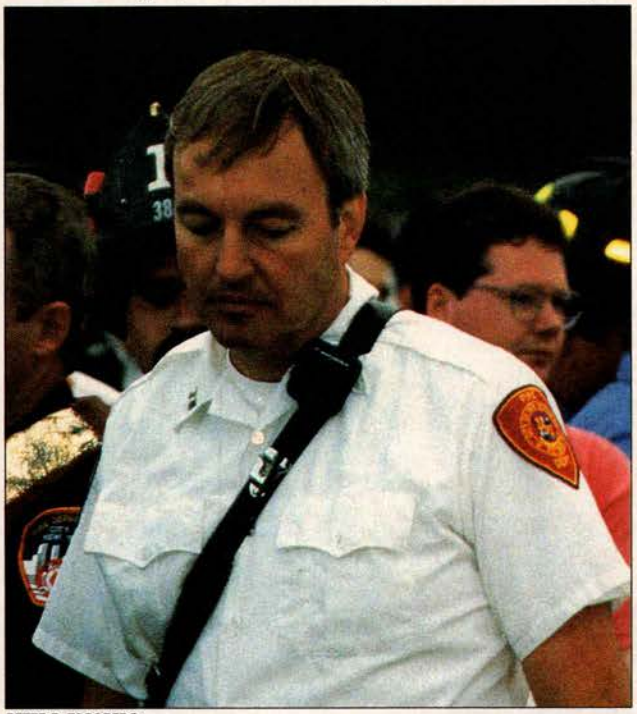
the Opportunities

But as you near the school, a police officer's voice comes across the radio. He's out of breath, and he's talking in short, gasping bursts. He tells you to head for the auditorium and pleads for you to hurry. Without slowing, your partner swings into the school driveway and drives past several yellow buses up to the auditorium door. You grab a drug box and race in. It's dark, but your eyes quickly adjust. Several people are bent over a small figure on a brightly lit stage.

Vaulting onto the stage, you drop to your knees beside the figure, a little girl. She is perhaps 8 or 9 years old, a small child dressed in a bright pink leotard, white tights, and small, delicate ballet slippers. Her neck is arched back in an unnatural stretch, and there is a tight, almost imperceptible jerking in her arms and hands. A frantic gray-haired woman is trying to wipe vomit away from the child's clenched mouth.

One of the adults tells you the little girl was dancing when she suddenly collapsed and started shaking. You quickly clear the airway and begin a survey. Her whole body is rigid. Her eyes are blank and are twitching to one side. Her respira-

BRIAN HAIMER



PETER R. ESCOBEDO

The deaths we see are not neat, gentle passings....

TOU STU

tions are shallow, fast and noisy. You realize this is no ordinary seizure.

As your partner looks for an IV on the thin arm, you feel hollow in the pit of your stomach. The thrill you normally have on a good call is gone. But the professional in you focuses on airway, oxygen, IV, medical control, diazepam, suction, backboard and stretcher. You're doing everything right, yet somehow, in the midst of all the action, your human side doesn't stop thinking, seeing and feeling. Chipped red polish dots her little fingernails. Beyond the clenched jaw, the face is innocent and charming. Several other girls in ballet outfits stand near the door, crying, as you wheel their friend to the ambulance.

En route to the hospital, the girl becomes less rigid, and the shaking stops. You let out your breath, begin to relax and pick up the radio to give a report. But suddenly you notice her chest is not moving. The report breaks off mid-sentence, and you snatch off the oxygen mask, lowering your ear to her mouth. There is nothing. You place your hand on her chest. Still nothing. A split second of panic hits, but just as quickly, the professional returns. By the time you reach the emergency department, you've intubated your patient and are bagging her rapidly. The little body has gone completely flaccid, and the eyes are vacant, with big, unmoving pupils.

Things do not improve in the ED. Activity swirls around the girl, but nothing works. Her pulse rate begins to drop, and before she's even off the stretcher, you are doing CPR. You can't believe how little pressure it takes to push on her small chest. Then, suddenly, it all comes to a quiet end as the doctor says in a flat voice, "I don't think we can do any more. Let's quit."

The ending doesn't fit all of the work you've just done. There's no ovation, no explanation, no celebration. Just silence. An hour ago, the little girl was dancing.

Filling out your EMS form, you feel hollow and empty. You wish you could have done more or at least known what went wrong. The doctor mentions cerebral hemorrhage and autopsy, but you need more than a medical answer.

Later, while cleaning up the ambulance at the end of your shift, you find a small, wrinkled ballet slipper wedged between the squad bench and wall. You pick it up and slowly turn it over and suddenly find yourself thinking about your beautiful niece.

This is tough stuff.

THE OLD DAYS of wiping off our hands and pretending nothing bothers us are gone. Today, the tough stuff of dealing with human tragedy, suffering and death in EMS is defined in terms of critical incident stress. During the past decade, we've identified the symptoms, participated in the debriefings and learned to manage the effects of the critical incidents, but experience suggests there's more to the tough stuff than critical incident stress and stress management. Working with suffering and death is a powerful—and indeed a potentially dangerous—human experience, but it is also full of surprising opportunity. Let me explain.

Tough stuff refers to the experiences that come with helping people in difficult and often tragic situations. It's the human, heartfelt part of EMS that goes beyond medical and scientific explanations. It may be a suicide, a rape, an out-of-control heart, an undramatic death in a nursing home, a bloody multiple-victim accident on a highway, a lonely homeless person or all of these piled up over a period of years. Tough stuff is the part of EMS that training and practice cannot prepare you for. Tough stuff is an experience.

Yet despite all the heartache tough stuff may create, it's the tough stuff that makes EMS such a unique field to work in. We routinely deal with a segment of life most people will never approach or experience. We live, for example, in a culture that is largely uncomfortable with suffering and death; with the urbanization of society and the fragmentation of extended families, caring for people in crisis—especially those who suddenly become ill or injured—has largely become someone else's job, someone else's problem. Most people don't have experience in dealing with human tragedy and want to keep it that way.

Have you ever noticed how, when we tell people we work in EMS, they often wrinkle up their noses and say, "I don't know how you can do that stuff. I couldn't handle it"? And they're right—most people couldn't imagine facing the tough stuff we experience every day, much less cope with it. But even within the medical field, the EMS experience is unique. Other branches of medicine practice in the sterile, controlled environment of the hospital or clinic, while we find and treat our patients in the raw, natural setting where they live. We find them in the elementary school, in bed, on the

PHOTO COURTESY PRISCILLA YOUNG

toilet and under wrecked cars. The deaths we see are not neat, gentle passings but are often sudden, messy and undignified. We do not have the protective setting of the institution, and we find human suffering in the ordinary places of everyday life.

But despite its everyday occurrence, tough stuff never becomes ordinary. It's not the sort of thing we can put aside when we change out of our uniforms. The memories remain and, like a soldier who has gone to war, the tough stuff affects us. The question is, how are we affected?

Beyond the Critical Incident

Jeffrey Mitchell's work with critical incident stress has been a godsend for this industry. His pioneering efforts at understanding stress and the debriefing process have matured into standard operating procedures in most services in the form of critical incident stress debriefing (CISD). As a result, most providers are well aware of the psychological danger of certain incidents. However, after years of street work, I'm convinced there is a subtle danger inherent in tough stuff—a danger that goes beyond critical incident stress. This danger is not readily apparent and is often not obviously debilitating, but those of us who have hung around EMS for a few years have seen it. The danger is the negative effects the accumulated experiences of dealing with human suffering and death have on life perspectives. It's the danger that the optimism and sunshine in life will fade behind a cloud of cynicism, bitterness and pessimism.

We can see this happening in the Hawkeye Pierce character on the old TV series "M*A*S*H." Hawkeye, a life-loving young doctor, finds himself in the midst of a confusing war in which his daily work brings an endless parade of senseless casualties from the battlefield. On the surface, Hawkeye copes well; he doesn't become crazy with stress, fall apart or quit. He may complain and act zany, but like many EMS people, Hawkeye has the admirable ability to clean up from one tragedy and move neatly to another.

But underneath Hawkeye's laughter and practical jokes, are the beginnings of a hard edge. The innocence of his youth begins to fade away as the series progresses, and his outlook on life begins to take on a pessimistic note. Everything he sees seems to suggest the world is in desperate shape, and the only relief he finds is in the "swamp" with his gin still. In one episode, after a long day of caring for wounded soldiers, Hawkeye tells his partner, B.J., that nothing seems to matter anymore. Nothing has any meaning. Each day has become a blur of senseless tragedies, and all Hawkeye wants to do is go home and forget it all.

But the problem is, he can't forget. Hawkeye's experiences with tough stuff have left a deep, dark impression that will not go away.

This darkness is a real danger of tough stuff. After dealing with tragedy after tragedy, we begin to wonder about the things we see, and slowly, the sweetness of life begins to sour. One paramedic described it this way: "I guess I've just got a screwed-up view of the world now. I used to believe in God—I thought somebody was in charge, but I just don't know anymore," he said. "I once went on this call where a 14-year-old boy hung himself in his parents' bedroom closet. We're doing CPR on this kid, and his mom comes in and starts complaining about the clothes we trampled cutting him down. That call was enough to stop me from believing in a lot of things."

Another paramedic said, "I still do calls because medic work is better than sitting in an office, but I don't have any dreams anymore. I used to think about going to med school or maybe starting my own business, but I've seen too much on the street to be a dreamer. Street work makes you pretty practical about life. We're all just here to see how far we can go, and if we're lucky, we won't get hit by a car."

These statements reflect what often happens to EMS street providers; taking care of other people's tragedies begins to wear us out. As one EMS veteran told me, "One morning you wake up and find you just don't care anymore. You may still do your skills OK because that's your job, but you don't give anymore. You stop doing the extra stuff. When I first started, I wanted to be the best I could be. I lived for EMS, but now there's nothing special about the work. It's actually pretty depressing. It's like all the stuff you see takes away your life piece by piece."

Essentially, then, the tough stuff gets mixed up with the grind of shift work and the struggles of life outside the job. We begin to feel our lives are going nowhere, we have no purpose and everything is boring, but it's difficult to say exactly what is causing it.

Let's look more closely at some of the ways tough stuff affects us.

"...a 14-year-old boy hung himself in his parents' bedroom closet. We're doing CPR on this kid, and his mom comes in and starts complaining about the clothes we trampled cutting him down...."

Tough Stuff: What It Does

First of all, tough stuff forces us to confront death and mortality. We may join EMS hoping to save lives, but we rapidly discover that even in the best of EMS responses, death often wins. Death is, of course, a natural part of the life cycle, but to experience life's sudden ending over and over can magnify it to such a point that it seems like life's only destination.

Looking through the shattered glass of a wrecked automobile at the obvious diagnosis of death, we confront our own mortality. We realize the person crumpled in the car could have been *us*. Most people would rather not think about death except at certain important times, such as at funerals and at the end of their lives. But as long as we work in EMS, we will face a continual and extremely vivid reminder that *you are but dust, and to dust you will return.*

Second, in working on the streets, we discover that much of the tragedy and suffering we see defies explanation. The tough stuff continually raises questions that have no answers. I once went on a call that involved a man who was critically injured in a car wreck just moments after his wedding ceremony. The wedding party, in long formal dresses and tuxedos, followed the ambulance to the ED, where the bride, in her bloody white gown, screamed and protested as her new husband was pronounced dead. She climbed onto the ED cart beside him and cried bitterly. "Why, God?" she screamed. "Why is this happening to me?" But there was no explanation.

The third way tough stuff affects our outlook on life is that it matures us before our time. Granted, everyone must eventually face tough stuff in life; even if we weren't in EMS, we would encounter tragic experiences and face our own mortality at some point. But the EMS experience compresses a lifetime of learning into a very short amount of time; we may see more tough stuff in a weekend than most people see in a lifetime. While such experiences are life-changing, the change may not be good: Like trying to rush the aging process of wine, we can become bitter instead of mellow. Like the boy who goes off to war and comes back a man, EMS forces us to grow up rapidly, but it's not always the sort of maturing experience we want.

These, then, are the dangers of tough stuff: It's the danger that slowly, over time, we will lose the joy and optimism in our work and life. It's the danger that we will become cynical toward our work, our patients and the world around us. It's the danger that everything will turn flat and colorless, that what once promised to be an exciting and full life will turn into an empty, hollow joke.

But these are only dangers—we need not become victims of the tough stuff in EMS. We are not determined by the things that happen to us; we always have

a choice in how we respond to life, even when it comes to the tough stuff. We can passively let the tough stuff squash us, or we can choose to see opportunities in it.

Opportunities in Tough Stuff

One of our strongest needs as humans is to find meaning in life. We want to know life is more than just a short, biological event. When we are old and gray, we want to be able to look back at life with a sense that living is more than just an exercise in survival. This desire for meaning is what makes us uniquely human.

Nothing seems to question life's meaning more than the tough stuff. Interestingly, however, it is in questioning the tough stuff that we *discover* meaning—often, something difficult or even tragic must happen before we see what's important. Like the pressure needed to form diamonds, the fire used to refine gold or the surgical cut needed to fix a wound, the tough stuff is needed to help us discover what really counts.

The reason meaning can be found in the tough stuff is that the difficult, mysterious and tragic things in life lie very close to those things that are beautiful, joyful and satisfying. The poet Kahlil Gibran described this connection of joy and sorrow when he wrote:

> *Some of you say,*
> *'Joy is greater than sorrow,'*
> *and others say,*
> *'Nay, sorrow is the greater.'*
> *But I say unto you,*
> *they are inseparable.*
> *Together they come, and when one sits*
> *alone with you at your board,*
> *remember the other is asleep*
> *upon your bed.*

In being reminded of our own immortality and confronting life's difficult questions, we are also presented with an opportunity to discover the value of our lives and what really counts. Tough stuff and meaning walk hand-in-hand.

Consider another character from "M*A*S*H." As commanding officer of the M*A*S*H unit and a doctor, Col. Potter sees as much tough stuff as Hawkeye does. In fact, being older than Hawkeye, Col. Potter has witnessed the horrors of both World War I and World War II, and yet his outlook on life is not bitter, cynical or pessimistic. Rather, he is optimistic and hopeful. He has a calm view of the future, and even though he is in the midst of war, he still sees enough beauty to paint pictures.

How is it that Col. Potter finds meaning in the battlefield experience while Hawkeye is overwhelmed by it? The difference is in how they *choose* to approach the tough stuff. Those of us in EMS have a similar choice to make: Finding meaning in the tragic events of EMS work is a personal choice that includes acknowledging the tough stuff, allowing ourselves to grieve and creating balance.

Acknowledging Tough Stuff

"Platoon," a dark movie about the lack of meaning in the Vietnam War, contains a powerful scene in which a group of soldiers returns from a patrol in which several comrades died. They are overwhelmed with grief, but in an effort to dull the pain, they stand in a circle with their arms around each other and begin to chant, "It don't mean nothin'. It don't mean nothin'. It don't mean nothin'." It is an awful scene that depicts an attempt to hide from the pointlessness of the war.

But tough stuff—even the tough stuff of a pointless war—can begin to have meaning if it is acknowledged. In the Constitutional Gardens in Washington, D.C., lies a black granite memorial. Invisible from the road, its two wings, stretching 247 feet, are filled with the names of the more than 58,000 men and women who died in the Vietnam War. As you walk down the cobblestone path, it is as if you are walking into the darkness of the war itself.

This memorial is significant because it is an acknowledgment that no matter how awful that war was and how much the nation would like to forget it, it really happened. And as that event—no matter how painful—is acknowledged, people begin to find meaning and experience healing: meaning in the courage and sacrifice of those who died, lessons in the horrors of misguided government policy and hope in the prayer that such events will never be repeated.

Unfortunately—and perhaps tragically—many EMS workers fail to acknowledge the tough stuff. Because it can be painful to remember and because so few calls are recognized as significant by the media, medical community or management, there is a tendency to simply ignore the tough stuff and move on, as if it's all "just part of the job." Yet to deny that we have experienced something serious is to lie to ourselves. The truth is, EMS is full of difficult and tragic experiences, and the first step toward finding meaning in the tough stuff is to acknowledge it. Like walking down into the Vietnam Memorial, we must allow ourselves to admit we are dealing with tragic events.

Acknowledging the tough stuff often produces powerful emotions, but it's important to let the emotions come. They are a sign that we are allowing ourselves to grieve and heal.

Allowing Ourselves to Grieve

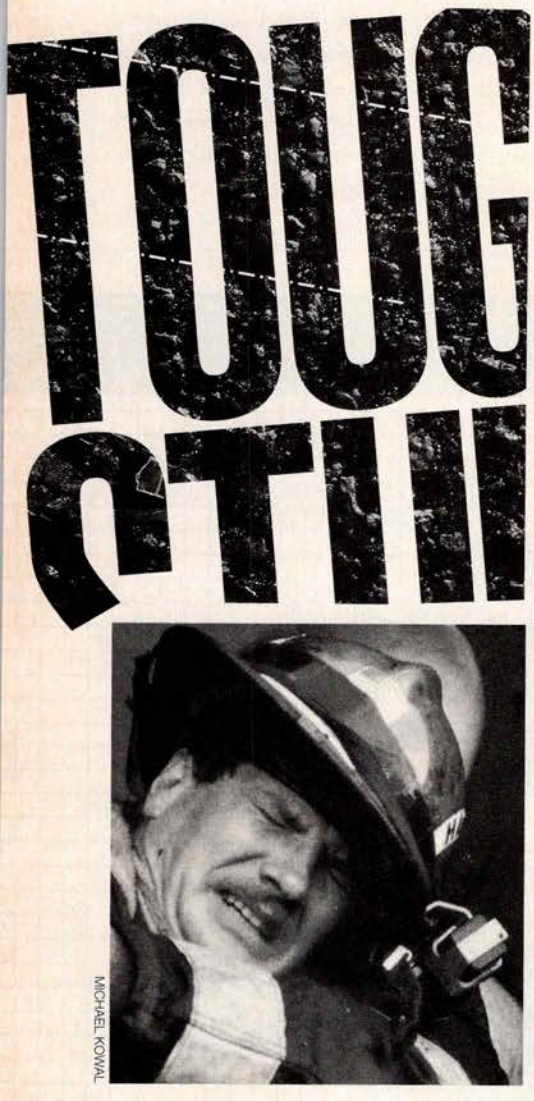
Why do we feel sad on certain calls? It seems silly—we don't know the people, and their sicknesses, injuries or deaths don't really affect our lives. We'll go back to the station, then back home, and our lives will not be changed by these other people's losses. So why do we feel sad? Why do we feel as if we've lost something?

We feel sad because, in a way, every person's loss is also our loss. Every time we experience a death, we are reminded of our own mortality. When we encounter someone else's tragedy, we feel sad because we cannot completely separate ourselves from the plight of humankind.

The strong emotional feeling we experience in tough stuff is called grief. Grief is the emotion or complex of emotions experienced in the loss of something or someone of value. The feelings we experience may include the entire spectrum of human emotions, including anger, fear, sadness and even hysteria. We allow ourselves to grieve when we give expression to these feelings.

Unfortunately, however, grieving is difficult for many of us. We can sympathize with our patients and comfort family members or even fellow workers, but we are often unable to express our own grief. Part of the reason for this stems from our inclination to care for everyone else. In being accustomed to taking care of others and paying close attention to everyone else's feelings, we often fail to recognize our own feelings of grief.

But not allowing ourselves to grieve is like denying a part of ourselves. The author Sam Keen says, "When we repress



MICHAEL KOWAL

To deny that we have experienced something serious is to lie to ourselves....

our grief, we blunt our capacity to experience joy." One of the opportunities of tough stuff is its ability to help us get in touch with our own feelings and perhaps a higher degree of joy.

Allowing ourselves to give expression to our feelings is a slow process, but it can be learned. At a recent workshop on grief, one paramedic said, "I haven't cried in years, and I don't think I want to. So how can I express the way I feel about something I find sad?"

Ignoring our grief leads to an emotional constipation that blocks our capacity for finding joy and meaning.

The best way to express grief is in whatever way feels most natural, and it's OK not to cry. We must begin by paying attention to our feelings. We must notice when something bothers us, and we must stop and take time to feel the emotion. Then we can try talking about our feelings with a partner or friend we trust. We should tell that person how we feel by going into detail, talking about an event and sharing what was specifically troubling. As we allow ourselves to talk and grieve, our emotions loosen and become unblocked. Sometimes as we express our grief about a specific call or situation, we find connections to feelings and memories from our past that seem totally unrelated to the call.

Recently, a paramedic told a story about trying to resuscitate a 43-year-old man who had arrested while working in his yard. Obviously the call was bothering the medic deeply, and he began to express his grief by yelling and swearing about his inability to intubate the patient. He continued talking, and his grief slowly took a personal turn. As it turned out, his father had died several years earlier in a similar situation. He had had many disagreements with his father and had not been able to make peace with him before he died. After nearly an hour of talking and a few silent tears, the paramedic finally declared, "I feel like I just vomited my guts out." And in a way, he had—he had vomited up some long-held grief for his father. Both old and new grief need to be expressed.

Ignoring our grief leads to an emotional constipation that blocks our capacity for finding joy and meaning. But in the very expression of grief, we begin to give meaning and value to the loss.

Seeking Balance

There's a good lesson to be learned from diabetic patients. Diabetics must maintain a delicate balance between their injected insulin and their blood sugar. A late night, a missed meal or stress can easily send these patients into shock if they do not carefully maintain the balance. The most healthy diabetics are the ones who learn to balance well.

Tough stuff is a lot like insulin. It can help us discover what is truly meaningful in life, but it can also be overwhelming if it's not kept in balance. Like insulin, it can creep up on us when we least expect it, leaving us flat and pessimistic and wondering why we're doing this work.

Unfortunately, many EMS people respond to tough stuff by working even more. They sign up for more shifts, take extra assignments and throw themselves back into the work. Granted, being busy can divert our attention for a while and dull the discomfort of tough stuff, but eventually it catches up.

Balance is created by acknowledging the tough stuff, allowing ourselves to grieve and knowing when to take a break. When we've had an experience of tough stuff, we need to get away from work and restore our energy and perspective. For me, this means spending some time in nature, with animals and away from the pressure of pager and telephone. Other people are restored by being around their families or by engaging in intense physical activity. Still others are restored through creative expression, such as playing music or painting.

As we allow ourselves to recharge, we gain a meaningful perspective on the tough stuff. In the long run, we gain much more energy and optimism by taking the time to balance, and in the balancing, we begin to discover how meaningful our work can be.

Finding balance also means cashing in on the opportunities of tough stuff. As we deal with other people's tragedies and then step back to balance, we will find a new appreciation for our own lives. At certain times we will feel fortunate just to be alive, and our problems will pale in contrast to those we have witnessed. The tough stuff can also give us a wonderful new appreciation for the people we love. Don't hesitate to celebrate such discoveries of meaning.

Tough stuff will never be easy to face, but as we become more in tune with our feelings and allow ourselves to acknowledge the tough stuff, grieve and balance, our perspective on work will change. A successful EMS worker is not one who learns to go on calls and feel nothing. Rather, a successful EMS worker feels others' pain and knows that such pain signals the value of the work and the people cared for. ■

John M. Becknell, a paramedic, writer and consultant in Minnesota, is a frequent contributor to *JEMS*. He has 18 years of experience in EMS.

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By Jeff Walkup, BS, EMT-P

ABOUT FOUR YEARS AGO, I stood before the governor of California and accepted a Certificate of Valor for my actions during the I-880 freeway collapse following the 1989 Loma Prieta (Calif.) Earthquake. The gold-embossed certificate reads, "For extraordinary heroism in the face of extreme danger."

At the start of my EMS career, I would have been overjoyed to hear the words "extraordinary heroism" and "extreme danger" attributed to me, but now, after eight years of street work, I feel differently. While I appreciate and honor my award, a more appropriate tribute to my career in EMS would read, "For extraordinary patience in the face of extreme frustration."

When I received my award for "heroism," I couldn't help but think the recognition was misplaced, for working on the freeway that night was exciting, dramatic and rewarding enough in itself. The people who really should have been recognized are the thousands of EMTs and paramedics nationwide who were spending that same night running routine, nonemergency calls. They could be found on street corners, in back bedrooms and on front porches fumbling with 2-inch tape, looking for matching slippers and trying to avoid needlesticks. That October night, I was experiencing the exciting promise of emergency work while they were experiencing the daily reality.

As I was being recognized that night, they were being forgotten—as they had been so many nights before.

The Hero Myth

Unfortunately, most of us in EMS have identified with—and indeed been attracted to—a very powerful myth: that of hero, rescuer and lifesaver. The myth promises us a steady stream of high-impact, high-velocity and high-reward experiences, yet the nonmedical and nonemergency reality of EMS repeatedly breaks this promise, leaving field personnel confused, frustrated, demoralized and burned out. I believe many of our problems in EMS (both as individuals and as a profession) can be traced to a mismatching of expectations. The hero expects—and depends on—the streets to provide real emergencies, but the streets often refuse to cooperate.

As my years in EMS have accumulated, I have come to realize the job of modern

street medicine often requires us to stretch far beyond the traditional role of hero. Indeed, the very real and enduring challenge of EMS has not been my ability to start two IVs in the back of a moving ambulance, intubate a breathing patient or quickly differentiate between pulmonary edema and emphysema. Rather, it has been my struggle to maintain a sense of purpose, professionalism and mental health when confronted with an endless string of nonemergency and nonmedical calls.

The Hero's World

It is important to remember that as EMS personnel, our job is unique within medicine, for our patients do not come to our world—we go into theirs. Unlike the controlled hospital or clinic setting, the EMS world is complex, dynamic and unrestrained. It is out of this soil that the nonemergency and nonmedical calls are born.

In the hospital, caregivers deal with a badly fractured jaw or limb; in the field, we deal with a fractured family, a violent society, rage and helplessness. In the hospital, they carefully listen to lung sounds; in the field, we listen to sirens, radios, screams and crying. In the hospital, they hang an IV bag and increase the level of Dilantin; in the field, we hang our heads and increase our distance as we walk among the sights and smells of poverty, filth and self-destruction. In the hospital, they manage a patient; in the field, we attempt to manage a world.

Our medical scenes are often complicated by the disturbing realities of a modern world: from disease, death and misery to ignorance, addiction and mental illness. Over time, from call to call, these realities chip away at our spirit, idealism and mental health. The effects are subtle and insidious.

These effects are only complicated—and perhaps worsened—by the fact that as a profession, we have received virtually no support in the form of training and education to help us deal professionally, sensitively and effectively with these realities. Critical incident stress debriefing (CISD) is a great start, but it mistakenly

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overlooks the chronic and cumulative effects of being repeatedly exposed to the disturbing nature of our working conditions.

The original architects and current leadership of EMS have done a good job educating us medically and technically, but they have failed to teach us how to deal with the perplexing social and psychological situations from which our patients must often be extricated. The EMS culture provides us with a mythology that attempts to compensate for this educational deficit. This mythology (adopted from the military) offers us a naive and simplistic notion of how to think, how to act and how to feel when confronted by a world that is often chaotic and senseless.

Without accurate expectations and good coping skills, however, we frequently end up stumbling over and aggravating the very situations we are being asked to manage and calm. Even more disturbing is that over time, we find ourselves reflecting many of the same symptoms as our patient populations. Beneath the surface of our crisp uniforms, official patches and shiny badges often lie anger, cynicism, bitterness and apathy.

Removing My Hero's Mask

It is said we spend the first half of our lives with the face we are given and the second half with the face we earn. As EMTs and paramedics, we have been given a face, a role, an identity—that of hero, rescuer, lifesaver. I have gone en route many thousands of times in search of this face, only to find disappointment and frustration in its place as another "emergency" turns into a bloody nose, the flu or a taxi ride to the hospital.

A struggle would rage deep within me as each attempt to see myself as the hero was lost to the stubborn nonemergency reality of modern street medicine. Because I am human, the frustration would often escape my control and find itself predictably entangled in my relationship with the patient and others—at odds, in conflict and unprofessional.

Fortunately, though, underneath my mask of hero, slow and fundamental change was occurring. Change driven by the endless repetition of what I perceived as nonemergency contacts—like change that occurs to bedrock when persistently pounded by the surf, ultimately yielding sand. The product of my struggle was the realization that I had been attempting to perform a role that did not fit me or accurately match the demands of my work. But what role do I play if not that of the hero? What, then, will guide my behavior

and give me a sense of purpose, impact and gratification, if not the hero?

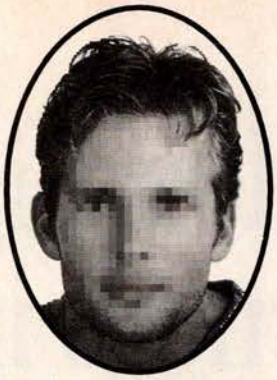
I found the answer to these questions in a mirror—a mirror forged by my mind's ability to compress the many thousands of calls, with their nameless faces and smoky memories, into a single reflective surface. Standing before this mirror of my experience, I chose to remove the face I had been given: that of hero, rescuer and lifesaver. What I saw looking back at me was at first shocking and then humbling, for I saw the face I had earned, and it was ironically little different from that of my patient: imperfect, angry, struggling and frightened.

With the removal of the hero's face came a reawakening of my interest and motivation in paramedicine and a welcomed change in my behavior—I had finally come to the clear realization that "the problem" was not the cut finger, the street person, the neck pain, the 400-pound back pain or even our dispatchers, but rather my expectations—expectations driven by the need to see myself as hero.

As I practiced going on scene less as a hero and more as a human being, I began to observe remarkable changes. First, I observed the differences between my patients and myself spontaneously collapse. For me, this was the beginning of what I now see as true empathy, understanding and patience, and the end of my days as an EMS "cowboy," complete with an attitude of superiority, arrogance and toughness.

Second, I noticed concrete changes in the way people reacted to me on scene. It was as if I had completed some sort of silent initiation process that now permitted me to belong, to participate, to witness. I no longer felt like the outsider or rookie curiously poking around the perimeter of people and worlds I did not understand. Instead, I found myself identifying with these worlds, and as a result, I no longer fought against them, but rather, I fought for them.

Third, I dramatically improved my street sense—that is, my ability to ensure my safety and influence others. I no longer pushed people around to get what I needed; instead, I worked more harmoniously with others on scenes. I knew more instinctively how to talk, how to act and how to feel, for I needed only to ask myself: How would I feel? What would I need? How would I like to be treated?



To remove the mask of hero and replace it with our own face is difficult, for we risk having to look at ourselves—our fears, our limits and our own wounds.

In retrospect, it is remarkable and even a little humorous that the part of my job I found the most frustrating over the years—the nonemergency call—actually turned out to be *my* hero, *my* rescuer. It forced me to sit down before a mirror, and in that mirror, I was forced to admit to myself a sober truth, a truth I had attempted to conceal behind the confident mask of the hero. It is the truth that I, like every human being, am limited, confused and vulnerable.

I came to understand that the myth of the hero was a tool I used to protect my vulnerability, empower me and guide me through the disturbing nature of this work—the unknown, the strangers, the sights, the sounds, the feelings. But over time, it became obvious that this tool was painfully inadequate and was often at the heart of my conflict, for the hero has little tolerance for the nonemergency call. Rather, the hero much prefers—and perhaps seeks—the spotlight of glory and recognition. Unfortunately, however, humanity most often struggles outside the spotlight, where it is dark and not so glorious. I believe it is outside the spotlight and away from the earthquake, plane crash or shooting that the real and unrecognized work of EMTs and paramedics is done—day after day, night after night—not in saving lives, but in helping lives.

Redefinitions

I believe the current and popular definition of hero oversimplifies our work and limits our contribution to humanity by suggesting our value only be found in high-impact medical situations that emphasize real emergencies, speed and the saving of lives. We must push for educational curricula that expand our training beyond that of technician and clearly prepare us to deal with the challenges and stresses of a dynamic and unrestrained work environment.

To remove the mask of hero and replace it with our own face is difficult, for we risk having to look at ourselves—our fears, our limits and our own wounds. But the hero, like a child's kite, can fly for only so long above the noisy streets before being pulled to the ground by the sobering realities of modern street medicine. We need to remind ourselves that every act we do and every word we speak is meaningful and full of impact, for humanity moves forward less by dramatic acts of heroism and more by quiet acts of idealism.

We need to talk more about the idealism and less about the heroism. We need to remove the mask and see who we really are.

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Author's Note: *Special thanks to Gary Walkup and Sandy Tong, EMT-P.*

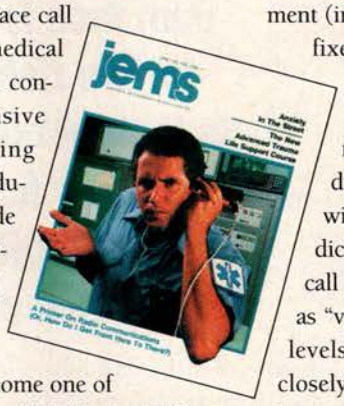
The 15 Most Significant Influences in EMS in the Past 15 Years

THIS YEAR, *JEMS* CELEBRATES its 15th anniversary. Much has changed in EMS since that first issue of *JEMS* was mailed. Many of you have been there, witnessing every change. Others of you are just starting your careers in EMS—our next generation. We hope at our 20th, 25th and 30th anniversaries you are still a part of this exciting profession. As you participate in the growth and development of one of the most important aspects of health care, you will witness your own changes in EMS.

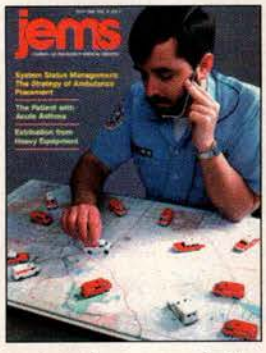
No one at *JEMS* can predict what EMS will look like in 2010, but as the saying goes, you can't know where you're going unless you know where you've been. So here, in more or less chronological order, are our choices for the innovations and trends that have had the largest impact on EMS between 1980 and today. Enjoy!

1 Medical priority dispatching and EMD training

Prior to *JEMS*' publication of Jeff Clawson's innovative dispatch program, only the federal government and a few EMS systems had experimented with training programs for emergency dispatchers, call screening (which denied service to some callers) and medical self-help instructions from dispatchers to callers. But Clawson's approach to dispatch was to create a new profession—emergency medical dispatcher—and replace call screening with medical priority protocols, conduct comprehensive dispatcher training and continuing education, and include pre-arrival instructions with all emergent calls. Since then, the dispatcher has become one of the most important links in the EMS system. The expanded role, improved training and education, and the influence of a popular TV series ("Rescue 911") have combined to change standards, not to mention public expectations, for emergency medical dispatching.



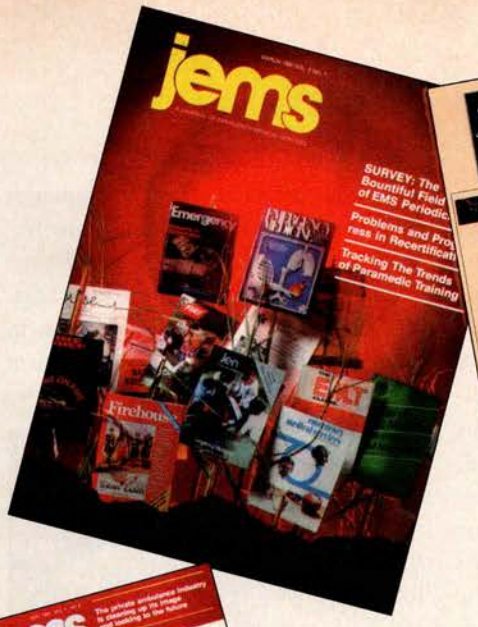
2 Ambulance deployment and staffing innovations

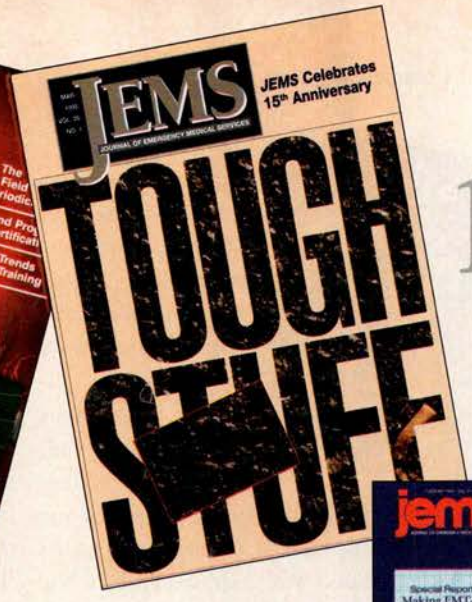


In the early 1980s, mostly through the creativity and writing of economist and EMS consultant Jack Stout, traditional methods of staffing and deploying ambulances were being challenged. The new concepts being proposed replaced the static mode of deployment (in which ambulances are based at a fixed location until called) and the 24-hour workshift with a concept called system status management (in which ambulances are deployed to various locations within a service area based on predictions of when and where the next call will occur). An alternative known as "variable staffing" (in which staffing levels during a 24-hour period more closely match the anticipated levels of demand throughout a 24-hour cycle) was also introduced. Because these changes affect the productivity and working conditions of ambulance personnel, the changes have been controversial from the start. Differing opinions continue as to appropriate levels of productivity and the effects of these innovations on employee morale, health and longevity. (For more on Jack Stout and his concepts, see **Management Perspective** on page 173.)

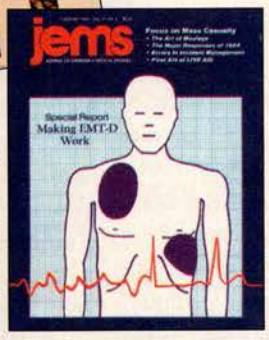
3 The American Ambulance Association's strategic plan, including CAAS and MTI

Until 1983, the private ambulance industry had been unable to organize and maintain an effective association to represent its interests in a cohesive manner on a national basis. In 1983, the American Ambulance Association sponsored a strategic planning process which pro-





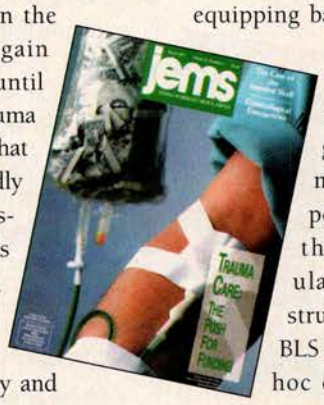
1980-1995



duced numerous recommendations. These included the creation of a national ambulance accreditation process (now known as the Commission on the Accreditation of Ambulance Services) and the Management Training Institute, which has since trained hundreds of owners and managers in running an ambulance service. And since 1983, the AAA has grown steadily in membership, influence and financial strength.

4 Development of trauma care systems

Although this development got its start in Illinois and Maryland in the early 1970s, it didn't gain momentum nationally until the early 1980s. The trauma system concept dictates that if necessary, the most badly injured patients be transported past other hospitals to specially equipped, staffed and designated facilities. This concept sparked great controversy and intense competition for trauma center designation and for trauma victims. In some areas, however, almost as soon as the dust had settled on the designation issue, economic factors combined with increases in urban violence to make trauma center designation a financial liability. Fifteen years later, many trauma centers have relinquished their designations, and some major areas of the country are suffering shortages of specialized facilities for this category of patients.



5 Automatic external defibrillation

The technology of automatic defibrillation had existed for several years before it gained acceptance with cardiologists and EMS medical directors. Finally, controlled studies in Iowa and several other locations were conducted to prove the safety and efficacy of equipping basic life support personnel with automatic defibrillators. In the aftermath, some manufacturers began developing both automatic and semi-automatic portable defibrillators. Still, the EMS laws and regulations in most states obstructed use of the devices by BLS personnel. In 1983, an ad hoc conference of physicians, program directors and researchers set interim standards for automatic external defibrillation, and *JEMS* published those standards. In a relatively short time, state EMS agencies began to update their laws and regulations to accommodate this innovation. Less than a decade later, the American Heart Association recommended that AED equipment and training be provided for every first responder unit.

6 Focusing on the emergency needs of children

As most people in EMS know by now, children are not miniature adults, and their medical needs are quite different from those of adults. In 1985, the federal government recognized this and gave a tremendous boost to pediatric EMS by establishing and funding the EMS for Children (EMS-C) grants program. Since then, EMS-C projects in more than 40 states have received grants through the Bureau of Child and Maternal Health of the U.S. Public Health Service. In fact, the EMS-C program has been much better funded than any other federal EMS pro-

gram. In 1992, a *Newsweek* exposé on the shortcomings of pediatric EMS sparked renewed activity in this area, including a move in many states to mandate funding for state EMS-C offices and programs.

7 Adapting to the wishes of terminal patients

In 1980, the prevailing attitude was that the EMS system had an obligation to take all possible steps to prevent or delay death in all life-threatened patients, regardless of the patient's condition, prognosis and wishes. That attitude reflected a cultural bias toward saving lives at all costs. As the population has aged, however, and the issue of "death with dignity" has become part of the national discourse, many physicians and their patients have demanded a softening of the mandate that all patients be subjected to the indignity, pain and cost of medical heroics in the face of an end-stage disease process. Many medical-legal apprehensions were moderated by the development of living wills, do-not-resuscitate orders and durable powers of attorney. Some EMS systems have now adopted various tools to help identify those patients who have chosen not to be resuscitated, and to give EMS field providers guidance in the time-sensitive, life-or-death environment of cardiorespiratory arrest.

8 Infectious disease epidemics

Nothing has affected the relationship between EMS personnel and their patients more than the recognition and increased prevalence of lethal infectious diseases.

Commencing with the recognition of the AIDS virus as a blood-borne pathogen, EMTs and paramedics began to adopt protective measures, equipment and apparel. Apprehension among caregivers has been enhanced by increased encounters with patients suffering from other communicable diseases such as hepatitis and the resurgence of tuberculosis. This apprehension was underscored by a few reports of fellow EMTs and paramedics who had contracted deadly diseases through patient contacts. The challenge for educators and EMS managers has been to encourage maintaining adequate protection while ensuring that EMS personnel remain respectful of and committed to the medical needs of suspected infectious disease patients.

9 Responding to EMS stress

While the stresses suffered by EMS workers had been recognized for several years and numerous articles and books had addressed the topic, the importance of EMS stress achieved full recognition in the late 1980s with the organization of a national network of critical incident stress debriefing (CISD) teams. This development signified the impact on prehospital EMS workers of factors such as exposure to multiple casualty incidents and human tragedies, increased workloads, more complex procedures and protocols, more demanding training and recertification requirements, and unstable or insensitive political and management environments.

10 The fire service awakens to EMS

After many years of apparent disinterest in EMS despite the increasing involvement of thousands of local fire departments, two of the major fire service organizations issued a joint resolution in support of fire service EMS. Management (the International Association of Fire Chiefs) and labor (the International Association of Fire Fighters) jointly committed to an effort to increase the fire service's roles and responsibilities for delivery of prehospital EMS. While this action did not produce immediate changes throughout the fire service, it was seen as supportive of the goals of a new generation of fire service leaders. During the past five years, fire departments from coast to coast have become increasingly interested and aggressive in their efforts to elevate their levels of prehospital care and, in many cases, to compete with the private sector for the right to provide their communities with ambulance service.

11 The epidemic of violence

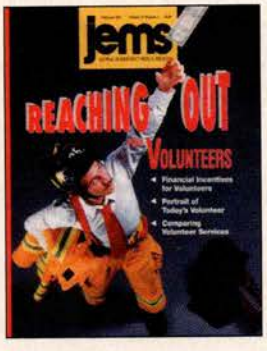
The frequency of life-threatening violence, especially in urban areas, began to have major impact on prehospital EMS providers. In some cities, crime statistics showed that assaults and homicides had doubled or tripled. Of course, this was not news to people who had served on rescue units and ambulances in those areas. Complicating the challenges of working in the midst of such violence was the fact that it was often aimed at EMTs and paramedics themselves.

In some locales, EMS employers now issue armor-resistant garments for their personnel (although in many others, it remains up to the EMT or paramedic to

purchase their own ballistic vests). Special training is provided to make EMS workers more aware of potentially dangerous situations, personal safety and gang activities. Although the statistics now show a decline in the frequency of violent crimes nationwide, many areas remain very dangerous for EMS workers. As much as any factor, the epidemic of violence robbed many in EMS of their innocent but admirable attitude of compassion for all patients, regardless of behavior and circumstances.

12 The vanishing volunteers

From the beginning, rural and suburban areas of the United States have depended heavily on volunteers for fire protection and prehospital EMS, including ambulance service. Throughout the past 15 years, however, change has had its impact on volunteer emergency services. The jobs of rural and suburban volunteers have shifted to urban centers in many cases, requiring long commutes and restricting the time available for volunteer duty. The social benefits of belonging to a volunteer organization became less attractive as more leisure time was consumed by family, second jobs and other responsibilities. These changes have combined to make it difficult for many organizations to attract and retain volunteers. During the same period, increased population in most areas brought with it increases in demand for service. Moreover, modern standards were accompanied by time-consuming training and continuing education programs. In some cases, paid crews have been employed to provide daytime coverage. In others, ambulance service has been turned over to a full-time public agency or private service. While some volunteer EMS services remain strong and reliable community resources, the American tradition of volunteerism has eroded in most areas.



13 The Prehospital Care Research Forum

Despite the abundant energy, commitment and enthusiasm of most people in EMS, this field has been at risk since its earliest days as an organized activity. That's because, for the most part, we have not demonstrated (in scientifically defensible terms) that what EMTs and paramedics do for patients in the field makes a positive difference. Of course, all EMS workers have plenty

of individual examples they can rely on to feed their sincerity and commitment. But these anecdotes cannot pass muster in a scientific forum or when competing for limited funds. Since September 1980, when *JEMS* published its first research report, the *JEMS* staff has worked to inspire and assist the production of similar reports based on carefully analyzed patient outcomes. Scientific proof remained sporadic, however, until the creation of the Prehospital Care Research Forum. This group's effort (cosponsored by *JEMS*) has since produced a steady flow of EMS research that promises to bring out-of-hospital care into the realm of scientific respectability.

14 Continuous Quality Improvement

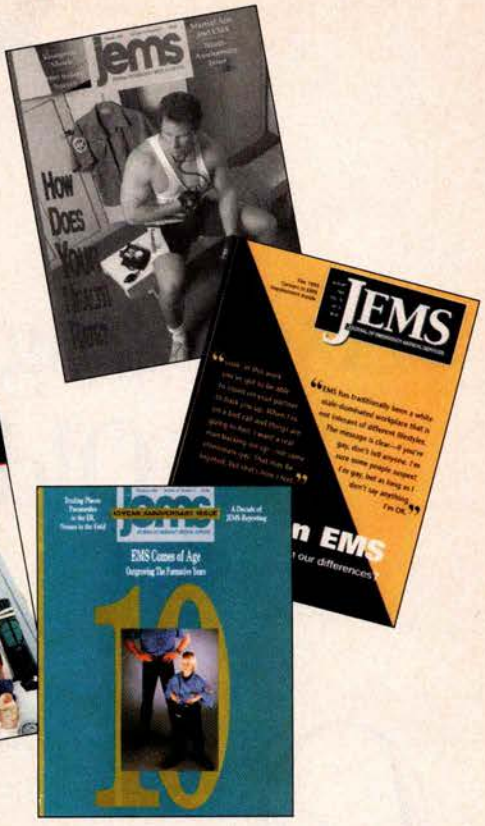
In the early days of EMS, providers relied on the quality assurance (QA) practices of medicine and hospitals as the guiding influence over efforts to control and regulate prehospital emergency care and transportation. Traditional QA, however, had failed in hospitals, and it failed to achieve the desired results in EMS also. It was a retrospective concept, reviewing patient care performances after the fact, looking for errors, assigning blame and then taking "corrective action" against individuals. Some have referred to it as a "bad apple" concept—trying to find bad apples and then eliminating them in the belief that the system will thus get better. In most cases, however, people quickly learned how to prepare documentation to foil the QA process, regardless of whether the paperwork accurately portrayed what had occurred. Continuous quality improvement (CQI), by contrast, assumes that people want to do a good job, and it concentrates on processes rather than people. CQI prospectively analyzes all the processes that comprise patient care, assesses those processes, redesigns them where necessary to limit deviation from accepted standards and then trains people in the redesigned procedures. All processes are continually evaluated (none are ever considered as good as they can be), and all workers are encouraged to participate in the ongoing assessments. CQI was formally adopted by the Commission on the Accreditation of Healthcare Organizations in 1993. Since it is a never-ending process and a radical departure from long-accepted behaviors, the EMS community has been slow to implement CQI. However, we predict that eventually it will prove to be one of the most important developments of the past 15 years.

15 The specter of health care reform

As with all aspects of health care, the proposal by the Clinton Administration for radical reform and federal control

absorbed the attention of the EMS community through most of 1994. Although Congress failed to pass a single piece of health care reform legislation, the pressure to control costs accelerated several trends in health care delivery and finance. In the shadow of the debate over health care reform, managed care networks are forming and consolidating hospitals and related institutions from coast to coast. At the same time, health maintenance organizations, preferred provider organizations and other innovations are forming and growing at a rapid pace. These developments will be followed by redefinitions of service areas, capitated service contracts, prospective reimbursement and the development of EMS cooperatives as wholesalers of ambulance service. EMS workers increasingly will become involved in efforts to get the patient to the right bed the first time (regardless of municipal or county boundaries), immunization of target populations and preventive health education. It will be a new and exciting era that will thoroughly transform EMS over the next 15 years.

So, there you have it: *JEMS*' summation of the past 15 years in EMS. Although your 15-trends list may not be consistent with ours, we're sure you'll agree it will be fascinating to look back from the year 2010 and see the changes that will have occurred during the next 15 years.



CE Article

Assessing Trauma in The Older Patient

By Jonathan Newman, REMT-P

OLDER PATIENTS ARE MORE VULNERABLE to the effects of trauma than younger patients. In a group of patients with the same injury severity, the older patients (65 years of age or older) are more likely to suffer an increased number of complications and fatalities.[1] Older patients not only suffer physical trauma from their injuries, but they also may undergo significant lifestyle changes after recovery.[2]

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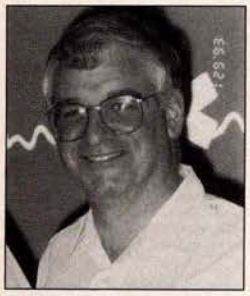
PHOTOS TOM PAGE
ILLUSTRATIONS MARGIE CALDWELL

By Andrew Stern and Edward Dickinson

All Patients Are Created Equal



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Ed Dickinson, MD, NREMT-P, *is director of EMS for Albany Medical Center's Department of Emergency Medicine and medical director for the Town of Colonie Department of Emergency Medical Services. An emergency medicine physician, paramedic and instructor, he has been involved in EMS for 15 years.*

WHILE WORKING A NIGHT SHIFT one summer evening, a paramedic team responds to a report of an unconscious female in an upscale suburban community. On arrival, the responders find an unconscious woman who appears to be about 55 years old lying supine on a lawn. A bystander informs the paramedics that the woman is frequently seen walking by herself and that while walking this evening, she stopped and sat down. According to the bystander, when someone approached the woman, her eyes seemed to roll back, and then she passed out. Someone walking by immediately called EMS.

On initial assessment, the patient is breathing, with snoring respirations. After a jaw-thrust maneuver is performed, she begins breathing quietly at a rate of 28/min.; oxygen is immediately administered via a nonrebreather mask. A cardiac monitor is placed on the patient, and a heart block is identified, with a rate of 55. Her blood pressure is 100/70.

Taking a "calculated risk" as to which patients may be infected with bloodborne pathogens based on lifestyle and the environment in which they are found is not only foolhardy but also dangerous.

The paramedics decide an IV should be started prior to moving the patient to the ambulance. A police officer who also responded to the call uses his flashlight to help the caregivers see better; one of the paramedics inserts an 18-gauge needle and notes an immediate flashback. As the paramedic removes the stylet, however, the police officer accidentally kicks the paramedic's elbow, and the needle punctures her glove. The paramedic notices the needlestick but continues to treat the patient; the IV is secured, and medical control is contacted for patient care orders, after which the patient is moved to the ambulance.

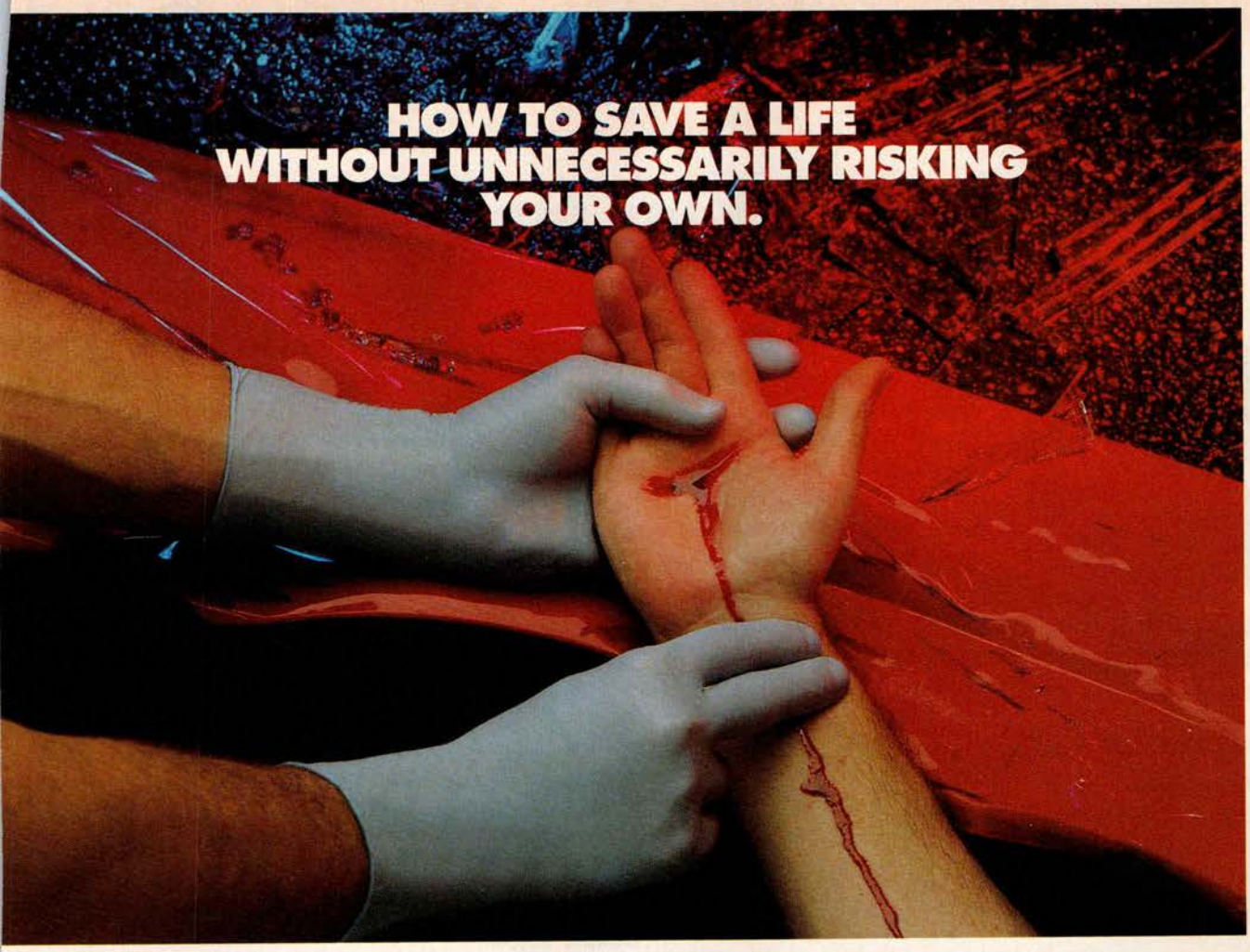
After the patient is loaded, the paramedic who sustained the needlestick removes her glove and notices a small trickle of blood near the puncture site. She cleans her hands with an antiseptic wipe and regloves. The patient is transported to the hospital, where she is admitted to the coronary care unit.

Shortly after the patient is turned over to the hospital, her son arrives. He states that the patient is a widow who lives by herself and that she has a history of cardiac problems, but he knows of no other medical problems.

Before leaving the hospital, the paramedic thoroughly cleans the wound site. On arrival back at the station, she contacts her infection control officer, and the necessary paperwork is completed. The injured paramedic is offered an immediate post-exposure follow-up but declines, believing there is no risk based on the patient information. Several days later, the paramedic learns the patient is HIV-positive, likely the result of a blood transfusion during hip replacement surgery eight years earlier.

It's Out There

Numerous articles have been published recently regarding the percentage of HIV patients encountered in emergency departments.[1–5] While these studies have varied in patient population and the types of patients (medical vs. trauma) included in the sample, all have identified some HIV-positive patients. In one suburban area, for example, the number was as low as 0.2 percent, while a large urban medical center found 8.9 percent of the patients to be seropositive. Yet, regardless of the locale, it is highly likely that many of the patients included in these studies arrived by ambulance. Therefore, even though these numbers vary, it is safe to assume the pres-



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ence of HIV or AIDS in any patient population is real, and it can't be ignored or underestimated.

One study profiled infected patients and found they varied in race, age and risk factor according to location of the EDs being sampled.[5] This points to the fact that over the years, the HIV and AIDS epidemic has progressed to all population groups in different parts of the country; it is no longer predominantly associated with gay men. IV drug users and individuals—both male and female—who have unprotected sex with infected partners are at significant risk also.[6] Still another population that has become affected is newborns. The Centers for Disease Control and Prevention reports that 7,000 infants are born to HIV-positive mothers each year.[7]

But Wait, There's More

While EMS providers are typically most concerned about HIV and AIDS, other bloodborne pathogens also pose significant risk. The hepatitis-B virus (HBV) and hepatitis-C virus (HCV), for example, are far more infectious than HIV and, if contracted, can be devastating.[3] In one study of numerous EDs, the HBV seroprevalence rate was found to be 2.6 percent, while another study of trauma patients identified the rate as 19.7 percent.[8,9] Still another study identified HCV among 7.7 percent of patients in one level-I trauma center.[10]

These numbers suggest that within the field of emergency medical care—and within medicine as a whole—bloodborne pathogens pose a real risk to caregivers. Furthermore, taking a "calculated risk" as to which patients may be infected based on lifestyle and the environment in which they are found is not only foolhardy but also dangerous. Yet, even while the dangers are there and documented, many health care providers still aren't taking steps to protect themselves. In one study of paramedics, only 62 percent of the providers reported having received at least one dose of the HBV vaccine.[11] This vaccine should be considered just as important for health care workers as gloves and other barriers. (The use of barrier protection is mandated by the Occupational Safety and Health Administration on every patient when there is exposure to blood or body fluids. Indeed, in some states, failure to follow these regulations is now considered professional misconduct and grounds for potential revocation of licensure.)

The bottom line is there is just no way of knowing which patients may be carrying bloodborne pathogens. Using social markers or environmental clues to make a calculated guess is inappropriate, unprofessional and dangerous. You just never really know. ■

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Inside EMS

EMS AROUND THE WORLD

AHA Wants Public to Defibrillate

Equipping ambulances and first response vehicles with defibrillators is a crucial link in the chain of survival, but the American Heart Association (AHA) wants to go farther. The AHA now wants to put automatic external defibrillators (AEDs) in public places, and in the homes of high-risk patients. The association also wants police officers, security guards and family members to learn how to operate them.

"This certainly is not going to detract from our emphasis on having [AEDs] available to trained rescuers," said Richard Kerber, MD, chairman of the AHA Subcommittee on AED Safety and Efficacy. "But in cases where immediate access [by first responders] is impossible, we want defibrillators to be available in places, such as offices buildings and hotels, where they can be used, say, by security guards."

Last December, the AHA sponsored a conference to look at the possibilities of public-access defibrillation, and in June the AHA Board of Directors approved a position statement on the topic. In that statement, the AHA said it would undertake new efforts to encourage "performance of defibrillation by in-home companions and by firefighters, police security guards and nonphysician care providers ... in rural communities and congested urban areas where [current] resuscitation strategies have little success."

To reach these goals, the AHA is working with manufacturers to develop simpler AEDs. "More are already starting to appear on the market," Kerber said. "But we envision a new generation of units even simpler to use—perhaps with less bells and whistles, but still able to defibrillate."

But for AEDs to become common fixtures—like fire extinguishers—in public spaces, they also will need to be much cheaper than those on the market today. "Our goal is for AEDs to cost $1,500," Kerber said.

To clear a path for public-access defibrillation, the AHA is "beginning legislative efforts in every state to look at their laws and give them some model legislation," said Patricia Bowser, coordinator of the AHA's AED Task Force.

In addition, the AHA is seeking help in funding a study—which could cost $10 million. Kerber said the study will involve placing AEDs in public sites, teaching people how to use them and then tracking the results.

"Obviously, since cardiac arrests are uncommon, we'll need to put a lot of those devices in a lot of sites," he said.

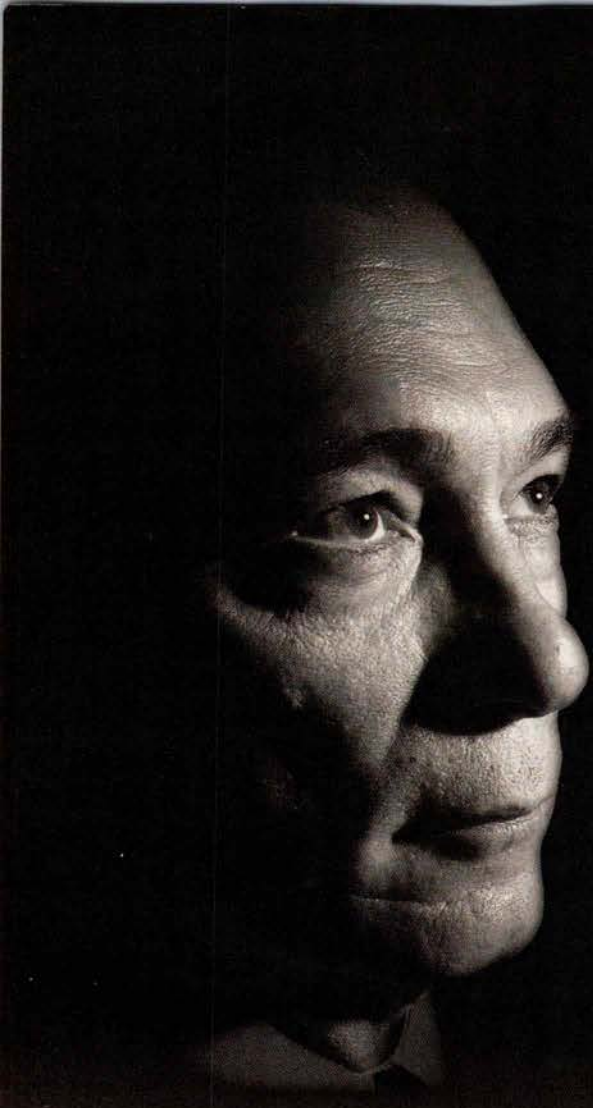
New & Noteworthy

Some firefighters found they could protect themselves from poison oak or poison ivy while fighting brush fires if they slathered exposed body parts with certain brands of underarm deodorant. Dermatologists got a whiff of this, performed some studies and reported in the September *Journal of the American Academy of Dermatology* that quaternium-18 bentonite, a claylike mineral used in some deodorants, binds to the plant oil and prevents it from penetrating the skin. If the Food and Drug Administration approves, a Kentucky pharmaceutical company will start selling it over-the-counter—minus the skin-drying ingredients found in underarm deodorants—within the next few months.

Honoring Fallen Heroes

NATIONAL EMS MEMORIAL SERVICE COMMITTEE

More than 700 people filled this Roanoke, Va., church at the Third Annual National EMS Memorial Service in April to honor 31 paramedics and EMTs from 13 states who have died in the line of duty. The memorial was founded by the Virginia Association of Rescue Squads and recognizes both paid and volunteer medics. If someone in your service has died in the line of duty and hasn't been recognized by the memorial, notify the National EMS Memorial Service Committee (1904 Byrd Ave., Suite 211, Richmond, VA 23230-3028; 804/282-3311, fax 804/282-9847) before Dec. 31. The Fourth Annual National EMS Memorial Service is scheduled for May 2, 1996, during EMS Week.



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Alabama—Medics received four hours of continuing education credit for taking a class on how to use the state's new scannable patient care reports, which will automatically feed PCR data into a computer database.

California—Stephen W. Ammerman, MD, an emergency physician and inventor of the Ammerman Halo cervical-immobilization device, died of an accidental drug overdose Aug. 15. Ammerman was working on a revolutionary new spinal immobilization system and writing screenplays.

District of Columbia—Former cardiac surgeon Sen. Bill Frist, R-Tenn., helped save the life of a man who suffered cardiac arrest near his office in the Capitol building Sept. 14 by performing CPR until an ambulance crew arrived.

Georgia—When a 21-member panel advised awarding the 9-1-1 contract for Atlanta and the rest of Fulton County to American Medical Response, Fulton County Commissioners decided they needed more information before acting on the recommendation. AMR's bid was chosen over joint bids from Rural Metro and Grady Memorial Hospital and from CareLine and Atlanta South Ambulance. "It's a political hot potato," said Joseph Fulton, MMS, PA, chairman of the RFP committee, "Grady has been in business more than 100 years, and CareLine and Atlanta South have been here for a long time, but AMR is an outsider."

Indiana—Rural Metro Corp. announced Sept. 21 it had signed a letter of intent to acquire AID Ambulance of Indianapolis. . . . When first responders arrived at the scene of a car crash in Indianapolis Sept. 23, they found that instead of performing first aid on the vehicle's four occupants, bystanders were looting the vehicle as the driver lay dying inside.

Iowa—The Bedford Volunteer Ambulance Service in Taylor County, which has no physicians or hospitals, won a $2,000 award from *USA Weekend* magazine and the Points of Light Foundation for organizing a local health fair in which they gave free blood-pressure tests and taught teen-agers and teachers CPR and basic first aid.

Kentucky—As part of a new contract signed between the city of Louisville and International Association of Fire Fighters Local 345, the city's third-service EMS agency is being integrated into the fire department, which has been renamed the Louisville Fire and Rescue Department.

Maine—State EMS officials recently unveiled a proposal to totally redesign the state's EMS regulations and infrastructure to work with managed care organizations (MCOs). The plan, which was approved by the state EMS board in June, would set up regional medical dispatch centers, integrate medical direction with MCO primary-care access points and provide incentives for improved ambulance service.

FLORIDA

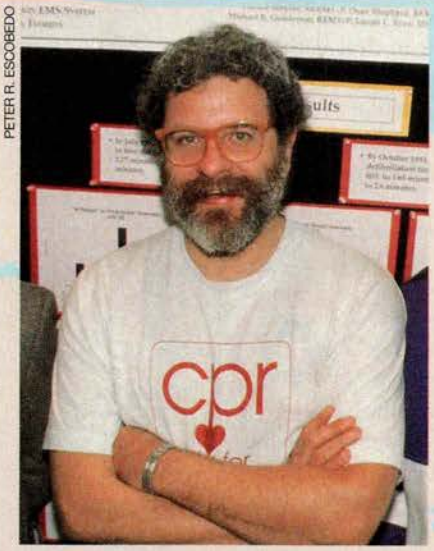
Medical Director's Pay Questioned

Joseph L. Ryan, MD, medical director of Pinellas County EMS and a nationally known EMS figure, came under fire in his own community recently. The local press had a field day after a county audit surfaced in September showing that Ryan, whose for-profit corporation (he's the sole stockholder) holds a $1.35 million contract to run the office of the medical director, kept $179,985 left in the budget at the end of fiscal year 1993-94. Add that to his base salary of $147,420 and the $81,887 he was paid (at $65 per hour) for providing on-line medical control, and Ryan made a total of $409,292 from the county last year.

But Ryan and Pinellas County administrators said the figures are misleading.

"This was all on the up and up," Ryan said. "It's basically a 1.1 percent profit amortized over the length of the contract."

PETER R. ESCOBEDO



Joe Ryan, MD, Pinellas County (Fla.) EMS Medical Director

"They looked at the only year [out of four that] the corporation made a profit," said Pinellas County's EMS Director Guy Daines. "The contract we have with Joe is for a fixed price. If it costs him more [to run the medical director's office], he has to pay it. If it costs him less, he gets to keep the money." Besides, Daines added, "Joe is a tremendous visionary and has done a great deal for us."

Gaines' sentiments were echoed by Assistant County Administrator Gay Lancaster. "Dr. Ryan is eminent in the field, and we don't think his contract with us is unreasonable considering what he provides—especially when you look at physician salaries," she said.

But Ed Hooper, president of the Pinellas County Council of Firefighters said most Pinellas County medics—many of whom earn less than $10 an hour and "have to work a zillion hours just to make a living"—are not happy with Ryan.

"I don't think he has violated the law," Hooper said. "But he's certainly taken great liberties ethically."

Cooperative *continued from page 19*

Solano County EMS Administrator Michael Frenn said a new joint powers authority" (JPA) representing provider agencies should take over the county's EMS administration and begin brokering services in February 1996. "We hope to have our whole 'bag of goods' ready by the end of June 1996," he said.

Solano County's plan is much like the new EMS-system design being developed in Alameda County, Calif., (see "Shaping the Future of EMS Delivery," March *JEMS*). But Alameda County plans to keep its EMS authority instead of replacing it with a JPA or co-op board. Also, unlike Solano County, Alameda County plans to operate a separate nonemergency triage center where calls can be transferred if a dispatcher determines the caller doesn't have a medical emergency.

"The plans are philosophically and operationally similar," Frenn said. "But Alameda County is four times bigger than Solano County, and their inertia is four times greater than ours, so we'll be able to put [our plan] on the street faster."

You won't believe...

A Sticky Situation. Ten sixth-graders in Glendale, Calif., were tested for the AIDS and hepatitis B viruses after their teacher used the same pin to prick their fingers so they could look at their blood under a microscope. Apparently, the teacher—who also teaches a health class, in which she lectures on the dangers of sharing needles—did wipe the pin with alcohol before reusing it on each student.

Currently, three private services—American Medical Response, MedTrans and a small company, Medic Ambulance—operate in the county. But the cooperative will select a single ALS transport agency through a bid process, although the only fire department in the county now providing ALS transport will continue to do so. "Other fire departments in the county aren't interested, at this point, in providing transport," Frenn said.

The plan was developed, at least in part, to deal with the growth of managed care. Eventually, the cooperative will negotiate with HMOs to pay a "capitated" amount each month to cover the estimated cost of any ambulance services their members might need. "This clearly is the way of the future for EMS," Frenn said.

(For more on the EMS cooperative concept, see "Cooperation: An Alternative to Consolidation or Bankruptcy," April 1994 *JEMS*.)

OOPS!

In August **Inside EMS**, we printed an item under the heading "Overheard On Line" concerning a supposed field study in Pittsburgh. We have since learned that the information we "overheard" was completely false: Pittsburgh has never done any field research on lidocaine. We regret any embarrassment we may have caused the Pittsburgh-area EMS community. This incident illustrates the need for extreme caution when using any information distributed by way of electronic mail and other computer bulletin boards.

Marion Angell Garza, *JEMS* news editor and editor in chief of the *EMS Insider*, coordinates this column.

USA

Massachusetts—If SB 1859 (also known as EMS-2000) passes the legislature, a surcharge on traffic-violation fines will provide funding to develop a statewide EMS system. . . . In two days in mid-September, five top executives of American Medical Response sold more than 200,000 shares of personally held AMR stock for $28 to $29 per share.

Mississippi—After a complaint that a call to 9-1-1 went unanswered for 13 minutes, a dispatcher in Ridgeland was fired for allegedly leaving his console unattended for 45 minutes to help police book a prisoner.

Missouri—Following a two-day drill of a pilot program designed to provide on-site trauma care during a disaster, Air National Guard "Careforce" teams from five states immunized more than 2,000 St. Louis-area "medically underserved" children for childhood diseases and hepatitis B and performed more than 900 school physicals.

New Hampshire—When the state's new enhanced 9-1-1 system went on line recently, the first call received was from a Concord man reporting a loose moose.

New York—New York City*EMS paramedic Adam Brynes received a commendation from the city's mayor recently for jumping across 80 floors worth of empty space to reach four injured people trapped in an Empire State Building elevator. . . . Richard Gutwirth, a New York City paramedic and president of NYC*EMS union Local 2507 from 1990 to 1993, died of leukemia Sept. 21.

North Carolina—Cary McDonald, MD, assistant medical director for Wake County EMS and clinical assistant of emergency medicine at the University of North Carolina at Chapel Hill, became the state's new EMS medical director after Nick Benson, MD, president of the National Association of EMS Physicians, resigned to concentrate on his role as chairman of the department of emergency medicine at Eastern Carolina University School of Medicine.

Oklahoma—As a result of legislation passed this year, the new Oklahoma EMS for Children Resource Center becomes part of the state EMS system Nov. 1 to "maximize pediatric emergency care in Oklahoma through expert leadership, education, research and advocacy."

Pennsylvania—While an EMS crew transported and treated a 76-year-old Simpson woman who had suffered cardiac arrest, her 79-year-old husband coded in the front of the ambulance. The husband was DOA at the hospital; the wife was pronounced dead an hour later.

MARYLAND

BALTIMORE CITY FIRE DEPARTMENT

Representatives of SCM Chemical and its parent company, Hanson Industries, present an over-sized check for $12,142.05 to Fire Chief Herman Williams Jr. (third from right) and other officers of the Baltimore City Fire Department. The donation will buy pulse oximeters for the department's 18 medic units. (Reportedly, city officials are still looking for an ATM that can handle the check.)

South Carolina—Tim Wojcik, NREMT-B, director of a new campus-based volunteer first response unit at the College of Charleston in Charleston, sent out a plea over the Internet for donations of used equipment and a vehicle. (For more information or to donate, call him or Rick Krantz at 803/953-5499.)

Texas—A Hermann Life Flight air ambulance was en route to a scene Sept. 14 when it experienced dual engine failure. The pilot was able to land the craft, and all crew members escaped injury.

Washington—Two flight nurses, Marna Fleetwood and Amy Riebe, died and pilot Lee Bothwell was missing after a Seattle-based Airlift Northwest helicopter crashed into Puget Sound Sept. 11. Airlift Northwest's medical director, Michael Copass, MD, said the crash happened in fair weather and was the first serious incident since the flight program began in 1982.

Wisconsin—Bruce Cormican, an EMT with the Black River Falls Fire Department, died Aug. 22 after he was sucked into the undercurrent below Polly Falls in Manchester while leading an unsuccessful search for a canoeist.

Virginia—To The Rescue Museum reopened at a new location Sept 21; it's now at the Tanglewood Mall in Roanoke.

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The Mourning After

Grieving a Medic's Suicide

By John M. Becknell and Lauren Simon Ostrow

We in EMS are dedicated to the preservation of life. Our entire practice is about giving people the best possible chance to survive life's crises. In the classroom and in the streets, we are equipped with a set of tools and skills that we can draw on to accomplish each task.

Tragically, however, the very same education that empowers us to care for the sick and dying every day betrays us in the aftermath of a colleague's suicide. We feel betrayed because suicide flies in the face of everything we are taught to believe: that life has value, that we have the power to preserve life, and that people want to live. As one provider said, "Suicide seems to go against everything we're about."

Because suicide calls into question tenets at the very heart of EMS, we find ourselves completely baffled when a colleague in EMS dies by his or her own hand. Our discomfort first manifests itself in the lingering question "Why?" Why did this person choose death? There must be an answer, we reason. We are thus driven to find, or even manufacture, a plausible answer. Was there a note? Had he experienced something awful? Did she have a relationship or personal problem too great to bear? Was the suicide related to work stress, depression or some other illness? There must be a reason, we tell ourselves, and so we focus on trying to make sense out of the senseless.

After much soul searching, the answers we find rarely satisfy. We may conclude that there was stress, depression, or a cross too heavy to bear. But was suicide the only option? What about others who have led troubled lives yet carried on? What causes a person to choose death over life? Is there a genetic predisposition to suicide? Did the victim suffer from an unbearable lack of familial or social support? And slowly we begin to realize that we will never find the answers we seek.

Our questions often are accompanied by powerful feelings. We feel sad and empty and broken. Sad because we will never see this person again. Empty because we are deprived of someone we cared about. And broken because of death's finality and the impossibility of reversing the act.

The haunting feeling that almost surely follows is guilt. Could we have done something to prevent this death? Should we have been more aware? Was there not some way we could have intervened? Feeling a heavy load of responsibility is second nature for rescuers. After all, we are in a profession of helping others on the brink of death.

"I just can't accept that we couldn't have done more," said a medic from Georgia about a partner's suicide. "We messed up some place." EMS people are the last to give up on saving a life. We always want to try one more time, give another bolus of Epi, try one more shock. We don't yield easily to death, so it is natural for us to think there must have been something more we could have done to prevent the suicide.

The crushing feelings of responsibility may be mixed with feelings of intense anger. "I'm damn mad he wouldn't let us help him," said the co-worker and friend of a flight medic from Minnesota who died by his own hand. "We would have done anything—worked his shifts, given him money, sat up all night with him, gotten him some help—but he wouldn't let us." Such intense feelings of anger are common

Stu Langford

"Stu's suicide left us all surprised and completely unprepared ... You think you know somebody and [then] they go and turn the whole world upside down. It shows how temporary your hold on existence is."

—Rick Bissell, PhD
Baltimore, Maryland

and betray the frustration, confusion and helplessness that a suicide leaves behind.

Perhaps the fear that motivates these powerful emotions is suicide's uneasy suggestion that life may not be as valuable as we believe. Even if our own lives are going well, the discovery that a co-worker has found life unbearable casts a shadow on our happiness. Part of the unwritten EMS philosophy is that, for good or bad, life has value. Yet the suicide of a co-worker reminds us that, at least for that person, life was not worth living.

Author Albert Camus wrote, "There is only one true philosophical problem and that is suicide." Whether the only problem or one of many, suicide confronts us with a tremendous challenge. Those of us left behind must somehow come to terms with the death and find hope. Robert L. Veninga, PhD, in *The Gift of Hope: How We Survive Our Tragedies*, writes, "The list of awful things that happen to good people is truly imposing. Yet within any aggregate population that has suffered a tragedy, there will be a high percentage who will move on and live productive lives." How can we move beyond the tragedy of a co-worker's suicide and survive? The answer lies in how we grieve.

Grief is the emotion, or complex of emotions, we experience whenever we lose someone or something we care about. Writing on grief, Leonard Zunin and Hilary Stanton Zunin offer this observation: "To grieve is to embark on a journey not of our own making. It is a journey that is both perilous and unpredictable." Grief is the result of how we integrate the loss into our life experience and accept it as part of our landscape.

Grieving does not come easily for EMS people. It does not fit neatly into our EMS mentality. In emergency work, we want and require quick solutions. Our working paradigm is one of solving problems in a hurry. We clean up after one tragedy and quickly move on to something else. We learn to rapidly put our feelings aside. But grief, especially when it strikes close to home, doesn't complete its cycle quickly. It is a slow process that often takes months and perhaps even years to complete. There is no short cut. Like the healing of a deep wound, the healing after a suicide takes time.

In addition to being impatient, EMS providers may find grieving difficult because our jobs have forced us to become quick-change artists. We learned at a young age that, in order to cope with the senseless tragedies we see on the streets, we have to construct a wall around our emotional core. We learn to put horrors out of our minds and find something else to pay attention to. The sad fact is that this emotional wall or shield makes us poor grievers. We have trouble letting go and identifying the overwhelming feelings of confusion, injustice, senselessness and despair that follow suicide. Even sadder is the fact that when we do stuff our emotions in a box and shut the lid tight, our grief manages to escape and trails us wherever we go.

So how do we break free from the shackles EMS has put on our emotions

and learn to grieve properly? From the myriad of literature on loss, we find there is no easy protocol for grief. Although each of us will grieve in his or her own way, here are some suggestions.

First, grief requires an acknowledgment that we have lost something. Just as our nation had to troop past the dark black, granite memorial to those who died in Vietnam to start healing, we also have to acknowledge that the suicide of a provider is a monumental loss, not only for family and friends, but for the EMS community as well.

Rick Mislan

"After Rick's death, the realization hit me: I do not have control over much. I can't 'fix it' for everyone. I can't stop them from doing this. And, most of all, I'll never understand it."

—Lee Jean Jordan, EMT-A
Carrollton, Ohio

Grief is more than an outburst of tears; it is the nagging feeling deep inside, the hole, the emptiness that comes whenever you think of the loss. It is the feeling that something is not right, that something is missing. And indeed it is. With suicide, more is lost than the life of another human being; a certain rightness and order to the world is lost. After a suicide, we lose a sense of innocence and faith that we can really rescue another person from his or her pain. Furthermore, we may question our notion that simply being alive is enough. Suicide calls into question our belief that life is valuable at all costs. To move toward healing, we must first acknowledge that we are grieving, that we have indeed lost.

As we acknowledge our loss, we can move toward the real work of grief, which is giving expression to our feelings. An old Turkish proverb says, "Concealed grief has no remedy," and H.W. Longfellow wrote, "There is no grief like the grief that does not speak." To grieve, we must find ways to express our sadness, guilt, anger, hopelessness and frustration through talking, crying, silence, activity, music or art. The expression of grief is much like breaking open a pus-filled sore; it can be painful, but when we express our sorrow, we will find a release that then begins the healing process.

Finding expression for our grief is very different from the popular belief that grief is conquered by forgetting. It is possible to put a loss out of your mind temporarily, but it never really goes away. Like a hidden splinter in your finger, it will fester. Expressing our grief requires remembering, allowing ourselves to feel pain and giving that pain a voice.

Jim Michaud

"One of the things that struck all of us was that he knew how to do it right. Because of his field, he used the drugs that he knew would do it, and there was no going back."

—Jan Straley, flight nurse
Minneapolis, Minnesota

Such expression requires others. Veninga writes that without exception, those who survive tragedies report they had the help of others. We all need to express our grief to someone—we need the community of others to help us through. Successful grieving is not a solo activity, and while we may have great confidence in our personal abilities, grief's expression requires reaching out to those around us. We often take great pride in our ability to withstand life's tough events in EMS, but a suicide in the ranks is too heavy a load to bear alone.

Robert O'Donnell

"We go out and bust our butts on a daily basis to save lives. [Then] to see people who have so much to live for [commit suicide], it confuses you ... It's a sad thing to see happen. There had to be a better way. [Robert and another firefighter who took his own life last year] left families, lots of friends and lots of people wondering why."

—Ray Sprague, EMT-P
Midland, Texas

Often, in our grief, we discover the real meaning of friends. Henri Nouwen wrote: "When we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving advice, solutions or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not knowing, not curing, not healing and face with us the reality of our powerlessness, that is the friend who cares."

During the grief journey, it is essential that we care for ourselves, although our rescuer mentality has us continually seeking to help others. Rescuing is a difficult habit to stop. But during the grieving process, we must take time away from the care of others to care for ourselves and to honor and live with our feelings. While distractions may seem to help, this is *not* the time to work extra shifts. It is not the time to take on new projects, or plan big life changes. It is a time to admit our sorrow, and give ourselves time to heal.

In literature, grief or sorrow often takes the form of a broken heart and, indeed, grief may be felt physically. Following a loss, we need to pay close attention to our physical needs. In the midst of sorrow, we may find ourselves skipping meals, losing sleep and focusing on anything other than the emptiness we feel. These physical changes are our bodies' way of getting our

Carol J. Shanaberger

"Her death gives us reason to pause and take stock of where we are, and what we feel. [It] forces us to recognize our exposure to the unrelenting stress of our jobs and that we must take care of ourselves as well as others. Extending our caring to ourselves and each other was the most important [thing] of all that C.J. sought in her short but profound life."

—Marvin L. Birnbaum, MD, PhD
Madison, Wisconsin

attention. Just as the cardiac patient needs to take special care of his or her healing heart, so too, the griever needs special care for his or her broken heart.

Look for things that soothe. Many people report that quiet time spent in nature is healing. Others find that being around supportive friends makes a difference. Still others find special solace in their religion or spiritual community. We need to find what works for us, for as Earl Grollman wrote of grief, "It is as individual as fingerprints." The important thing is to recognize the need for healing and honor that need.

Expressing our grief will assist us in transcending the guilt that suicide leaves behind. Our guilt often comes in an endless stream of "what ifs." The sooner these "what ifs" are expressed and laid out in front of us, the sooner we can realize that in our humanity we are limited, and thus, we begin to forgive ourselves.

The most difficult part of suicide is its unsettling, mysterious nature. As a culture, we are extremely uncomfortable with mystery. In suicide, no matter what we do, the mystery remains. As we come to accept the suicide of a co-worker, the questions continue. We never will fully understand why someone chose death, while the majority of us hunger fiercely for life. Perhaps it is in the process of becoming more comfortable with mystery that we can fully participate in the wonder and hope of life.

Suggested Reading

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Medic Suicide

What Can Be Done?

By Jeffrey T. Mitchell, PhD

People communicate remarkably well by choosing death over life. Emptiness, shock, disbelief, denial, loss, hurt, guilt, frustration, anger, sadness and confusion are words most frequently used by friends and family members when a loved one decides to tear him or herself from the fabric of life.

Coincidentally, these are the same words that describe the emotional states that drive people to commit suicide in the first place. People who commit suicide communicate to those around them, but unfortunately, they do not wait for an answer.

Last year, 12 police officers committed suicide in New York City. In 1992, three EMS personnel in New York City died by their own hands and three others died under circumstances that hint suicide may have been the underlying cause. And a few years earlier, three other New York fire service personnel also opted out of life by killing themselves.

The stories are similar in many areas of the country. For example, we recently were saddened by the suicide death of Robert O'Donnell, a Fort Worth, Texas, paramedic who helped rescue Jessica McClure from a well in Midland, Texas, in 1987.

The recent suicides of O'Donnell and other high-profile paramedics lead us to believe that emergency personnel are killing themselves in greater numbers than ever, although exact statistics to support this assumption are hard to find.

Unlike the dearth of suicide data among EMS personnel, statistics among others in similar professions bear witness to an ugly trend. These studies have found an elevated risk for suicide among physicians and other medical and allied professionals, pathologists and laboratory technicians, social workers, police officers and some male dentists. Vietnam veterans, many of whom currently work in EMS, also have a higher than average suicide rate.[1]

The elevated risk of suicide among police officers is particularly germaine to EMS because police officers work under many of the same stressful circumstances as EMTs. Consider the following list of stresses found in police work, as described by Francis L. McCafferty, et al, in "Stress and Suicide in Police Officers."[2] McCafferty writes, "Police officers are beleaguered and under siege not only from the criticism and complaints of citizens, but also from ... lack of professionalism (low pay), a feeling that his work accomplishes nothing, exposure to death and carnage, hostility on the part of citizens, shift changes, his superior's desire for performance, work overload, lack of participation in decision making [and] poor equipment." Many of these stresses also are present in EMS.

Whether we're talking about 10 suicides a year or one, those who supervise and lead EMS personnel in fire stations, paramedic crews, volunteer ambulance services or emergency departments feel responsible for the health and well being of their employees. It is the EMS supervisor's job to maintain the health and safety of those for whom he or she is responsi-

Factors That Enhance The Suicide Potential[3]

Although listed in relative order of importance, combinations of these factors usually exist. The combined effects of these factors may be stronger than if taken as separate entities.

Other factors that may influence a person to consider suicide are a lack of family support, a history of suicide in the family, job burnout, intense feelings of guilt for actual or perceived failures, the season of the year, criticism from people held in high esteem, a decline in physical health and suicides among friends.

- **Intense feelings of depression, hopelessness, helplessness, haplessness (things just keep happening to me) and worthlessness**
- **Mood swings**
- **Breakup or loss of an important relationship**
- **Job stress**
- **Severe financial problems**
- **Lack of helpful resources**
- **Use of drugs**
- **Use of alcohol**
- **Extramarital affairs**
- **Being the target of disciplinary action**
- **Easy access to a weapon**
- **Retirement from an action-oriented career**
- **Difficulties with living up to departmental rules, regulations and procedures**

ble during work hours. Moreover, like soldiers in combat, they also feel a powerful camaraderie as a result of the life-and-death circumstances EMS personnel face daily.

Why Suicide?

Why someone would choose suicide is an unanswerable question. The statistics do not offer a clear picture of the specific motives that drive people to take their own lives. Grief, depression, disappointment, loss of status or love, financial problems, loss of self image, fear, anxiety, anger, frustration, and excessively high expectations of life are among the many

What You Can Do

1. **Listen carefully.**
2. **Assess the situation fully to avoid under or over-reacting.**
3. **Offer friendship and understanding.**
4. **Suggest alternatives to suicide.**
5. **Suggest professional assistance.**
6. **Remove any stressful obstacles.**
7. **Validate his or her feelings: "Given the circumstances you are facing, many people would be thinking about suicide. But, suicide is a bad option. Let's work on some other alternatives."**
8. **Remove the person who has serious suicidal tendencies from the workplace.**
9. **Call the police, or bring the distressed person to a hospital, if necessary.**
10. **Do whatever is needed if a life is on the line.**

reasons implicated in suicides. Yet each of these emotional conditions offers only a partial explanation, and unfortunately, suicide leaves survivors with more questions than answers.

It is natural in our reasoning process to seek out clear reasons for events we don't understand. Suicide is no exception. It might help to know that very rarely does a suicide case answer the simple question of "why." Instead, most suicides follow a series of complex and interrelated circumstances, we call "emotional pile ups," that have built up over a long period of time. The result is an "emotional pile up" or "log jam" that clouds a person's vision of the future and causes him or her to lose sight of possible solutions to problems.

One factor almost always present in a suicide case is a final loss of hope. The suicidal person sees no end to the misery he or she is experiencing and that only one option remains—death. At this point, deep depression sets in, and there is a loss of the emotional and physical energy needed to ask for help. In addition, suicidal people begin to believe they are not worth saving and that no one would want to reach out to them anyway.

What Can Be Done?

Suicide prevention starts early in a person's life. Family, teachers, coaches, friends and professionals set the foundation that creates a secure, self-assured and self-reliant person.

While EMS managers cannot rewrite history and alter the way an employee was raised, organizations wishing to stop suicides among its employees must start early in the careers of its personnel. Independent thinking should be encouraged so that employees develop their self-confidence; finding more than one solution to problems encountered gives more options on how to manage life's problems. People who are aware of their options may be less prone to suicidal thinking.

Employees also need to know they are valuable assets to the company and that their opinions are important. Mistakes, of course, need to be corrected, but a person's self-image must not be attacked in the process.

Employees should be encouraged to call for help when personal and professional issues begin to seem insurmountable. Let employees know that calling for help is a sign of maturity and not a sign of weakness.

An important asset to any organization is to have in place a variety of programs that quickly identify employees at risk of suicide and provide them with appropriate interventions to lessen that risk.

Prevention programs include, but are not limited to, chaplain and clergy support activities, employee assistance programs, critical incident stress management teams, peer counselor programs and suicide prevention education courses for supervisors and command staffs. Each of these programs have specific roles and contributes to overall suicide prevention within an organization.

What Should I Look For?

The best assessment tools for emergency personnel to help a colleague are the ability to listen carefully and observe the behaviors of a seemingly troubled colleague. Without these skills, the threat of suicide may not be recognized until it's too late.

To help a friend past the possible threat of suicide, pay close attention to the pain in his or her life and the way the friend expresses that pain. Listen for hints that there is trouble at home or significant frustration at work. But remember, suicide is not always in a distressed person's thoughts; sometimes people are simply depressed but not suicidal. But without listening carefully, it is impossible to determine if a person is considering suicide. Learn to listen.

To be a good listener, you must have a good rapport with the distressed person. There needs to be a feeling of privacy so the person can discuss their personal issues, and the information discussed must be kept confidential and only given to professionals who will be handling the suicide intervention.

If a person has a detailed suicide plan, an attempt may be imminent. The suicide threat is especially serious if there are few resources available, such as family or friends, to support the distressed person. Alcohol abuse greatly intensifies the potential for a completed suicide, in most cases.[2]

When To Intervene

Obviously, there is considerable overlap between assessment and intervention. Once an emergency worker listens carefully to a distressed colleague and assesses that person's suicide potential, he or she has taken considerable steps in an intervention program against suicide. People pass through temporary crisis periods in which they contemplate taking their own

lives. It is well documented in stress literature that the most critical period is roughly 48 hours from the onset of the crisis state. With the proper support, the crisis may recede and never return.

If a person is experiencing a personal crisis and thinks such thoughts as, "I'd be better off dead," but does not have specific suicidal plans in mind, he or she is probably in need of friendship, good listening, professional support or general guidance. The crisis will hopefully pass without escalation into suicidal behavior, and if stress is reduced, the threat is usually lessened.

Changes in normal behavior, such as deepening depression, angry outbursts, deteriorating work performance, insomnia, unclear thinking, withdrawal and veiled or clear statements about suicide, are indicative of a more severe crisis state and a greater need for management to be aggressive in the intervention process.

If a suicide attempt occurs at the workplace, the police should be called; the safety of all members of the organization is essential. If needed, the person should be brought to a hospital for evaluation and treatment.

Successful Suicides: What Now?

Suicides of emergency services personnel can occur without substantial warning. A sudden suicide is an ambush on the emotions from which emergency personnel have a hard time recovering. CISD is helpful and should be provided. Some employees also will need additional support services, such as counseling, beyond the debriefing.

It is easy to blame oneself after the suicide of a co-worker. Ultimately, what needs to be recognized is that the deceased person chose death over life and that friends and family members who knew of the impending suicide did whatever could be done to prevent it.

No one wins in suicide. The devastation, the shock, the feelings of guilt in those who remain, the unanswered questions, the sense of emptiness, hurt, anger and sadness all indicate that the message from the deceased person has been received. If only they had heard the love, concern and empathy of those they left behind, suicide would never have been an option for them. Take the time, now, to reach out to someone in need.

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Awake and Hassled

What Stresses an EMT

By Edwin Boudreaux, MA, Cris Mandry, MD, FACEP,
Phillip J. Brantley, PhD, et al

Anyone working in EMS knows it can be a very stressful occupation. Even the most well-trained, thick-skinned providers will admit they sometimes return home feeling physically and emotionally exhausted.

Thus, it is no surprise that stress has been linked to other problems among EMTs, such as depression, substance abuse, negative attitudes toward patients, and job dissatisfaction. In extreme cases, an EMT may become so overwhelmed and distraught that he or she takes his or her life (see article on suicide on page 41).

While traumatic calls—such as mass trauma and pediatric injury or death—are serious and unavoidable occupational hazards among EMTs, research indicates that everyday irritants may be just as detrimental to their health and happiness. We found that the most common hassle on working days was the disturbance of sleep. Not only did sleep interruptions create stress among EMS providers, they also reported frequent interruptions in work activities, conversations, and during periods of "thinking and relaxing." These interruptions led to stress-provoking thoughts about unfinished tasks and unfulfilled plans.

The results of our research into the daily stressors among 40 EMTs employed by the East Baton Rouge (La.) Parish Emergency Medical Services revealed some suggestions for alleviating the common stresses often found in EMS.

We monitored stress levels for 30 days among 40 EMT-Ps. The subjects' ages ranged from 20 to 48. Eighty percent were male and all were Caucasian. The average time the paramedics had worked in EMS was 8.2 years.

Subjects were queried about their perceived stress using two assessment tests: the Daily Stress Inventory (DSI; Brantley & Jones, 1989), a well-researched, standardized measure of daily stress, and the Social Readjustment Rating Scale (SRRS; Holmes & Rahe, 1967), a widely used measure of major life stress. We included the SRRS in this study to replicate findings from previous studies. As Table 1 shows, the top 15 major life events reported on the SRRS by our sample of EMTs were very similar to those reported in other published studies.

Our research focused on two basic questions. First, we wanted to know if EMTs experience higher levels of daily stress than the rest of the population. Surprisingly, on the average, our subjects did not. As a whole, they experienced about the same amount of daily stress on the DSI as subjects from the general community. Further examination of the individual subjects' stress scores revealed, however, that some experienced almost no stress during the monitoring period, while others' stress measurements were nearly off the scale. Unfortunately, there were no reliable predictors determining

Table 1. **The 15 Most Common Major Life Events Experienced By EMTs, Using the SRRS as a Measurement.**

1	change in financial status
2	vacation
3	change in living conditions
4	personal injury or illness
5	change in sleep habits
6	change in work responsibilities
7	mortgage greater than $10,000
8	begin or end school
9	change in residence
10	change in work hours/conditions
11	outstanding personal achievement
12	change in eating habits
13	change in social activities
14	change in number of arguments with spouse
15	mortgage less than $10,000

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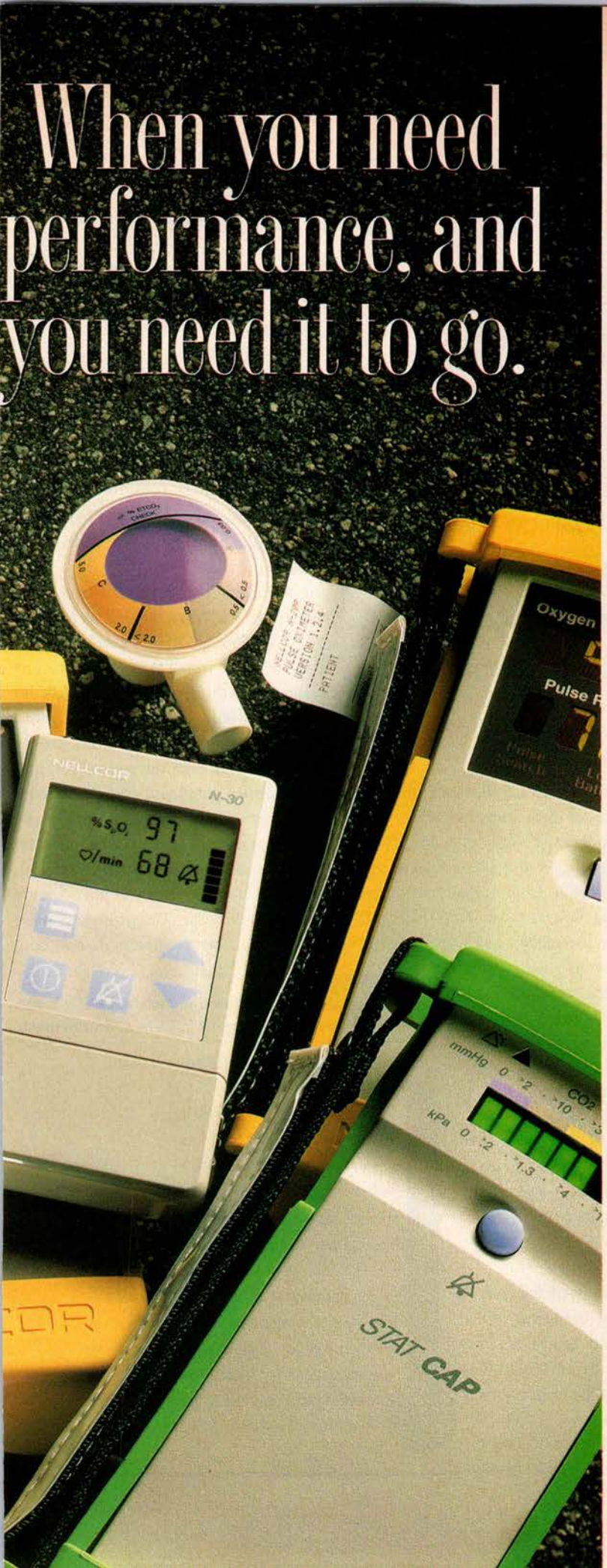

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which EMTs experienced excessive stress and which did not. Future studies, designed to replicate and extend these findings, should include personality and organizational variables. These may help to predict which EMTs experience excessive daily stress, such as stations that service impoverished areas high in violent crimes vs. those low in violent crimes.

Next, we wanted to find out the most common daily stressors among EMTs. Table 2 summarizes the most common daily stressors for work and non-work days. A particularly interesting and relevant finding is that four of the most commonly endorsed daily stressors were cognitive in nature: thought about the future, thought about unfinished work, worry about another's problems, and concern about personal appearance. These stressors were not specific events or stimuli that the EMTs were forced to face. Rather, this pattern indicates that EMTs do a lot of worrying both on and off the job. This also implies that cognitive stress reduction or distraction techniques may be appropriate.

Many EMTs work part time as firefighters or with other EMS services, so they end up doing the same thing during their spare time as they do during their work time. Moonlighting may help with their financial troubles (a common daily stressor reported by our EMTs), but it may also be an added source of stress. Getting involved in a non-EMS related activity on off days—such as hobbies, sports, exercise or social activities—may reduce worry and the nagging muscle tension and fatigue that often accompany it.

Many of the highest-rated hassles involved interruptions during some activity or the inability to complete plans for the day; this is expected on work days. However, the fact that interruptions and unfinished plans also occurred with high frequency on non-work days suggests that organization, time management and planning skills may need improvement.

The No. 1 stressor on work days and No. 7 on non-work days was sleep disturbance. While this is impossible to avoid on work days, considering the nature of EMS, the situation is not hopeless. One of the best things an EMT can do to rest better at the station is learn effective relaxation techniques. Although this may not always induce sleep, deep relaxation can serve as a substitute for sleep, thereby reducing chronic tension and making downtime more restful.

At home, some fairly simple, common-sense strategies can make disruptions less likely, such as wearing earplugs, playing relaxing background music, making sure the environment is suitable for sleep by regulating the room temperature and turning the telephone ringer off, and making sure that all family members know it is sleep time. When feasible, the EMT should set specific times when the family should be quiet and specific rooms for carrying on daily activities. Other general sleep tips are not to drink beverages containing caffeine or smoke cigarettes several hours before sleeping, restricting sleep only to one's bed, and taking a warm bath before retiring. Research and common sense support these recommendations.

This study helped to explore further common, everyday minor stressors EMTs face and pointed to some practical techniques that EMTs can use to reduce their daily stress. These suggestions were not exhaustive but, rather, provide a basic starting point.

Table 2. The 15 Most Common Daily Stressors Experienced by EMTs

DAILY HASSLES (Non-work Days)		DAILY HASSLES (Work Days)
thought about unfinished work	1	had sleep disturbed
thought about the future	2	thought about the future
unable to complete all plans for today	3	thought about unfinished work
hurried to meet a deadline	4	interrupted during task/activity
money problems	5	interrupted while thinking/relaxing
did something that you did not want to do	6	concerned about personal appearance
had sleep disturbed	7	hurried to meet a deadline
concerned about personal appearance	8	did something that you did not want to do
interrupted during task/activity	9	had difficulty in traffic
interrupted while thinking/relaxing	10	money problems
worried about another's problems	11	unable to complete a task
unable to complete a task	12	interrupted while talking
waited longer than wanted to	13	worried about another's problems
experienced illness/physical discomfort	14	unable to complete all plans for today
interrupted while talking	15	experienced illness/physical discomfort

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Additional Resources

Relaxation Training/Stress Reduction

Davis M, Eshelman ER, McKay M: *The Relaxation and Stress Reduction Workbook*. Oakland, Calif.: New Harbinger Publications, 1995.

Time/Personal Resource Management

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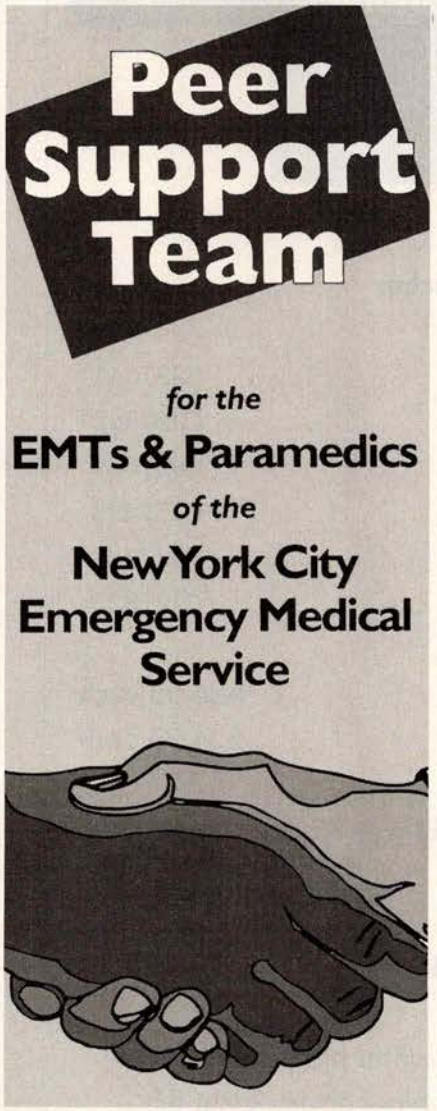
Stress Busters

Providers Offer Peer Support in NYC*EMS

By Lauren Simon Ostrow



What can we do for co-workers who are having difficulty handling stress in their lives? The EMS union in New York City has come up with an answer: we pull ourselves up by our bootstraps!

Officially known as the Peer Support Team for the EMTs and Paramedics of the NYC*EMS, this self-help program is a service of Union Local 2507, which represents the EMTs and paramedics of NYC*EMS. Originally funded by a $30,000 grant from the city of New York, the Peer Support Team was developed for union members to help other union members defuse stress.

The impetus for the program came from a series of city council meetings that focused on several provider deaths in NYC*EMS in 1992. Among those deaths, three were attributed directly to suicide, and three others were called "subintentioned deaths," in which the deceased had acted in a high-risk way that his or her professional training would have suggested was potentially dangerous.[1]

In addition to testimony at council meetings from Jeffrey Mitchell, PhD, and other experts on EMS stress, city leaders were swayed by the results of a study by Jose Sanchez, PhD, and Jack Kamerman, PhD, who examined suicide proneness among a sample of 261 NYC*EMS paramedics. Results of the study indicated that although a tendency toward suicide is "not really" measurable, among those medics interviewed, one quarter showed a medium to high inclination toward suicidal and parasuicidal behavior, as indicated by symptoms of depression, hopelessness, loss of control over important aspects of their lives and, to some degree, suicidal ideation.[1]

Unlike many peer programs nationwide that focus on peer CISD support, the Peer Support Team is concerned with daily, ongoing stress in all aspects of the paramedics' lives.

"The Peer Support Team is both an intervention and prevention vehicle designed to help members, their families and others significant in their everyday life," Program Coordinator Robin Lind said. "There is no limit as to the types of problems or issues that can be discussed." Results of a recent study among paramedics in East Baton Rouge (La.) Parish EMS confirm that the accumulation of daily stressors can be just as detrimental as critical incidents to the health and happiness of EMS providers.

In an effort to help providers cope with life stresses on an ongoing basis, the union trained 20 paramedics chosen from among 78 volunteer applicants to reflect the racial, sexual and religious diversity of the more than 2,400 union members. EMTs, paramedics, CROs and dispatchers are represented among the Peer Support Team members.

Once selected, the team underwent five days of intensive training. Two days were devoted to orientation and an overview of CISD. The last three days were spent on mastering the techniques of active listening, assessment, problem identification, intervention and referral.

Peer Support Team members are not instructed to intercede, as a psychologist or

counselor might, but, instead, to listen to the co-worker, assess the acuteness of his or her problem, provide support and, if necessary, refer him or her for outside help.

Union members were mailed pamphlets notifying them about peer-support services. The pamphlets included information about the confidentiality of the program, services offered, and the name of the team representative devoted to each borough of the city (Manhattan, Brooklyn, Bronx, Queens and Staten Island). Lind hopes that paramedics will seek out their support team members at their workplace or at a nearby station; however, team members also are available by pager, should the need to talk arise before or after a shift.

"Pagers were not our first choice. We had hoped for an 800 hot line, staffed in shifts with volunteers," Lind said. "It's good to pick up the phone and talk to somebody for reasons of anonymity, but there are not enough people to staff a hot line at this time due to funding difficulties."

The problems that paramedics raise with Peer Support Team members run the gamut from, "I can't stand my partner anymore," to "My wife wants to leave me," Lind said. Other commonly heard complaints include lack of recognition and accolades, poor public image, tough calls for new EMTs and paramedics (such as cardiac arrest), and job-related dissatisfaction. This seems to occur most frequently among paramedics who have five or more years in the industry.

With its seed money used up, the Peer Support Team faces a battle to secure more funding for continued operation into 1996. Like so many social services, quantifiable program benefits are difficult to measure, and as a result, funding may be hard to come by.

"The positive impact of our program may be too subtle to measure," Lind said. "Very often a good listening ear is all that is needed to alleviate a co-worker's perception of a problem. And how do you measure that?"

Reference

1. Sanchez J, Kamerman J: "A study of perceptions of emergency service work, suicide proneness and the utilization of employee services in New York City emergency medical service workers." Unpublished, 1993.

Hot Dogs, Houses and Hope

The 1995 *JEMS* Salary Survey

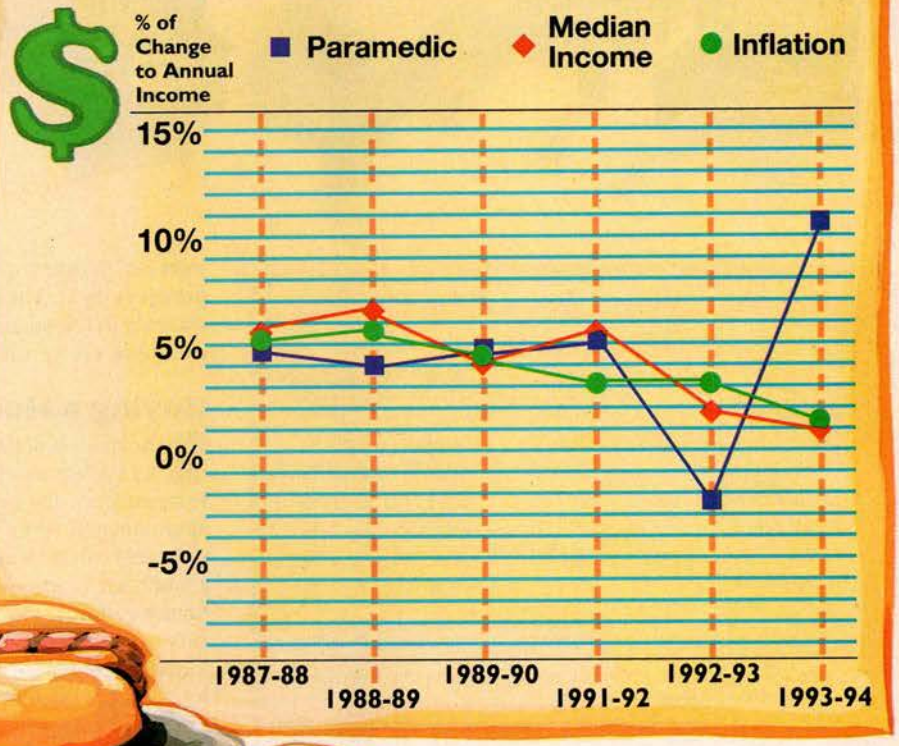
Well, what do you want first, the good news or the bad? The 1995 *JEMS* Salary Survey, our eighth annual look at wages, benefits, and purchasing power across the USA, offers up both.

In an effort to make these numbers understandable, let's start with the bottom line: salaries, which generally fall into the "good news" category.

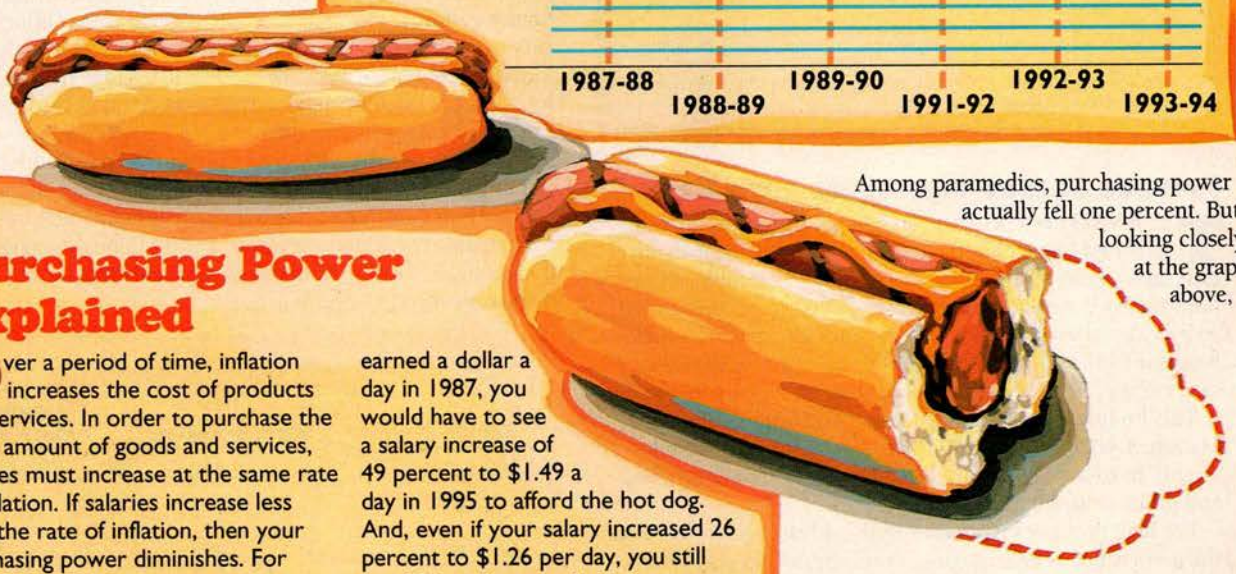
Unlike most Americans, whose purchasing power has decreased, those in EMS have more purchasing power. According to our survey results, EMS wage earners experienced an average salary *increase* of 3.5 percent between 1987 and 1994. This figure reflects an adjustment for inflation.

A salary increase, even a small one, is good news compared to the 12 percent *decrease* in purchasing power experienced by the average American since 1973, according to the Council of Economic Advisers. This figure also was calculated to allow for inflation.

Paramedic Purchasing Power



Among paramedics, purchasing power actually fell one percent. But looking closely at the graph above, things are not as bad as they seem. Since 1987, paramedics are faring better than average when one compares salaries to the rate of inflation.

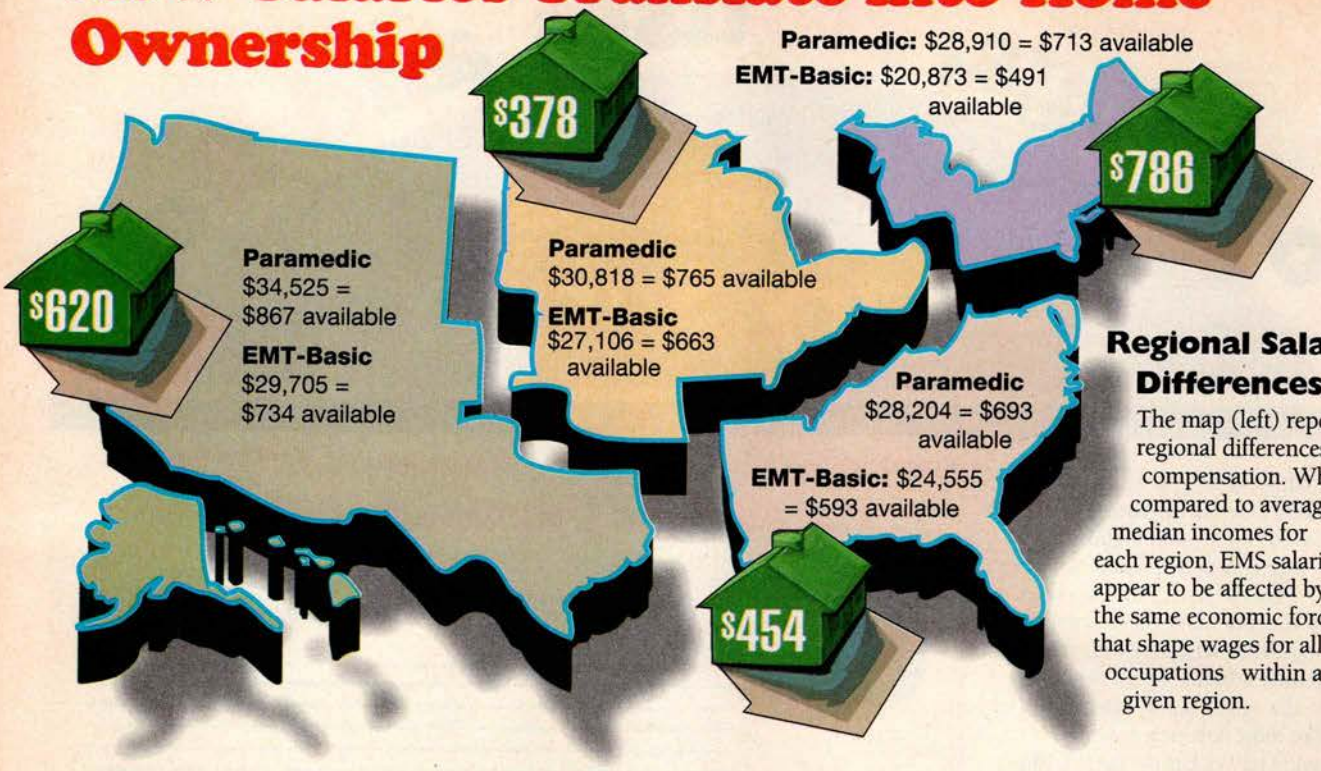


Purchasing Power Explained

Over a period of time, inflation increases the cost of products and services. In order to purchase the same amount of goods and services, salaries must increase at the same rate as inflation. If salaries increase less than the rate of inflation, then your purchasing power diminishes. For example, if in 1987 you could buy a hot dog for $1, that same hot dog in 1995 would cost you $1.49. So, if you earned a dollar a day in 1987, you would have to see a salary increase of 49 percent to $1.49 a day in 1995 to afford the hot dog. And, even if your salary increased 26 percent to $1.26 per day, you still would have less purchasing power and you wouldn't be able to buy the hot dog.

ILLUSTRATIONS BY JAMES MELLETT

How Salaries Translate into Home Ownership



Regional Salary Differences

The map (left) reports regional differences in compensation. When compared to average median incomes for each region, EMS salaries appear to be affected by the same economic forces that shape wages for all occupations within a given region.

Management Sees Big Gains in Private Sector

	1987	1995	% change*
Executive Director	$50,440	$107,750	57 %
Operations Manager	29,670	54,925	36 %
Ops Supervisor	27,330	40,375	9 %
Field Supervisor	23,750	34,437	7 %
Paramedic	21,330	28,619	–1 %
EMT	15,690	22,238	4 %
Dispatcher	18,140	26,301	7 %

*Percent change represents "purchasing power," the amount your salary can buy in goods and services. For example, operations managers can buy 36 percent more products than they could in 1987. On the other hand, paramedics can't afford to buy as much as they could in 1987, even though their salaries have increased.

Private Sector Managers Fare Best

The news is even better if you're in management; private sector middle and upper managers saw the most significant salary gains in the past seven years. For example, an operations manager working for a private, for-profit service earned an average salary increase of 36 percent (adjusted for inflation) between 1987 and 1994. During the same period, the average salary of a private service executive director rose by 57 percent.

This finding is consistent with many U.S. industries. Managers, charged with improving stockholders' or owners' wealth, have been rewarded substantially for cost-controlling and profit-enhancing successes.

For field providers who work in the private sector, however, the news is not as encouraging, ironically, for precisely the same reason: profit. Field provider salaries comprise the most significant cost of providing services. Therefore, the pressure is on private sector managers to control field provider wage increases in order to improve profits. Managers benefit, but providers don't. The profit motive contributed to a 1 percent decrease in the salaries, adjusted for inflation, of private sector paramedics since 1987.

Buying a Home

The news is not all bad for street providers, however. Using a new feature of the salary survey this year, we uncovered some encouraging news. In most parts of the country, within approximately seven years of entering the EMS profession, providers will have attained a salary that is adequate to purchase a home. Of course, where you live is a major determinant of housing affordability, and there are specific communities that vary from these estimates. Generally, however, our analysis found, in comparing regional salaries to average regional median house prices, that the majority of career-minded EMS providers can afford a home to call their own, provided that these employees keep pace on the clinical/adminstrative career ladder.

The apparent correlation between estimated mortgage payments and estimated disposable income was fairly strong. Northeastern providers, however, appear to be the exception, due to higher estimated mortgage payments relative to disposable income. (See map above.)

Better Than Average

Region	Median income	Paramedics Mean Salary
West	$29,942	$34,525
Central	27,108	30,818
Southeast	26,292	28,204
Northeast	33,971	28,910
U.S.	30,056	31,137

Climbing the Career Ladder

What Lies Ahead?

While salaries and housing prices vary from region to region, most providers can expect that their wages will increase as they move up the career ladder, regardless of where they live and work.

According to our analysis, the average increase one can expect when progressing between each clinical and supervisory rank is $5,710. Developing a career strategy is a sure bet to greater financial security and purchasing power in EMS. Schedule flexibility and down- time between responses offer an opportunity in many locations to start the step to the next rung on the ladder.

Where Do We Stand Among Health Care Workers?

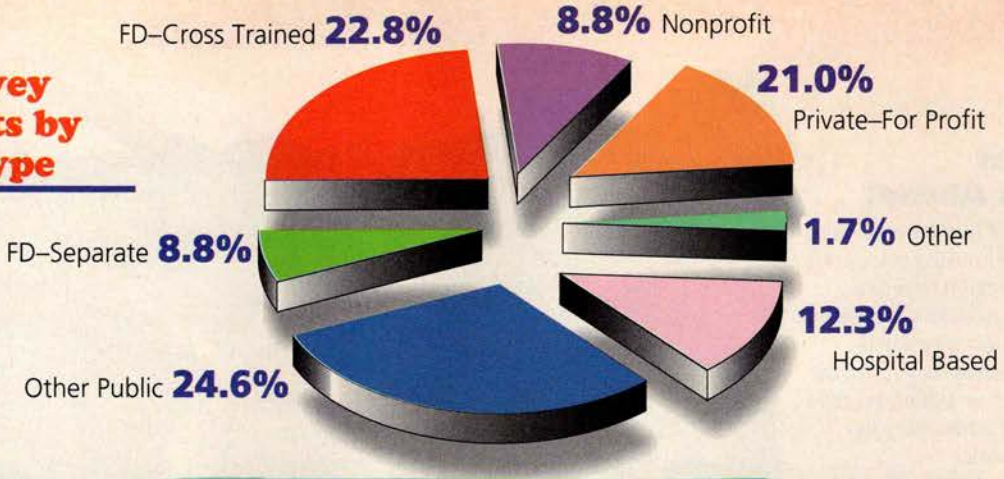
With the speculation surrounding expanded scope EMS, it is appropriate to ask ourselves how we compare with other medical professions. In this comparison, it is clear that education has a substantial impact on salary. Given that educational requirements for EMS personnel are less rigorous at the entry level (EMT-B) compared to other allied health occupations, EMS field providers' salaries appear to be in line with or are slightly better than what is to be expected.

EMS Holds Its Own Among Allied Health Professions

Occupation	Average Years of Formal Education	Average Salary
EMT-Basic	0.33 years	$26,333
Paramedic	1 year	31,137
Surgical Tech.	1.4 years	24,378
EEG Technologist	1.5 years	26,491
Radiographers	2 years	28,023
Dental Assistant	2 years	35,943
Sonographers	2 years	35,248
Radiation Therapist	2 years	37,500
Nuclear Med. Tech.	2.5 years	35,930
Physician's Assist.	4+* years	52,500

Source: *Occupational Outlook Handbook, 1994-95 Edition, U.S. Department of Labor, Bureau of Labor Statistics*

Salary Survey Respondents by Provider Type



Changes in Real Income: 1987-1995

	Executive Director	1987	Change	Admin Director	1987	Change
Private-For Profit	$107,750	$50,440	57%	$65,483	$33,830	42%
FD-Combined	67,551	47,380	5%	62,859	42,125	10%
FD-Cross Trained	69,631	54,130	-5%	67,573	52,500	-5%
FD-Separate	62,004	47,690	-4%	39,290	32,880	-12%
Hospital Based	58,000	36,000	18%	NR	33,170	NA
Other Gov't	56,570	42,600	-2%	40,438	34,640	-14%
Nonprofit	54,995			35,658		
Other	70,000	37,000	39%	NR		NA
Mean Salary	**$71,128**	**$45,050**	**16%**	**$52,732**	**$39,330**	**-1%**

	Operations Manager	1987	Change	Div Ops Supervisor	1987	Change
Private-For Profit	$54,925	$29,670	36%	$40,375	$27,330	9%
FD-Combined	65,410	41,560	16%	52,736	35,850	8%
FD-Cross Trained	66,509	50,500	-3%	55,200	42,540	-5%
FD-Separate	62,479	33,130	39%	46,577	26,250	30%
Hospital Based	44,800	27,090	22%	40,333	25,500	16%
Other Gov't	48,248	31,880	11%	39,877	26,410	11%
Nonprofit	37,828			33,248		
Other	42,000	22,500	37%	NR	20,000	NA
Mean Salary	**$53,532**	**$37,030**	**6%**	**$53,532**	**$33,420**	**18%**

	Field Super	1987	Change	EMT-Paramedic	1987	Change
Private-For Profit	$34,437	$23,750	7%	$28,619	$21,330	-1%
FD-Combined	42,466	31,170	0%	37,690	26,160	6%
FD-Cross Trained	43,470	36,030	-11%	40,650	28,700	4%
FD-Separate	40,859	24,930	20%	31,771	22,810	2%
Hospital Based	33,500	24,000	3%	29,264	20,380	6%
Other Gov't	35,499	24,090	8%	28,873	22,420	-5%
Nonprofit	31,987			25,700		
Other	30,000	22,500	-2%	28,000	23,000	-11%
Mean Salary	**$36,687**	**$28,470**	**-5%**	**$31,137**	**$24,100**	**-5%**

	EMT Basic	1987	Change	Dispatcher	1987	Change
Private-For Profit	$22,238	$15,690	4%	$26,301	$18,140	7%
FD-Combined	33,962	22,050	13%	20,051	21,440	-31%
FD-Cross Trained	35,524	26,100	0%	26,830	23,580	-16%
FD-Separate	30,317	18,000	24%	35,969	19,830	33%
Hospital Based	22,500	14,330	15%	20,583	16,350	-8%
Other Gov't	28,103	18,190	14%	24,394	19,050	-6%
Nonprofit	18,346			20,722		
Other	20,000			21,000	11,000	
Mean Salary	**$26,333**	**$18,710**	**3%**	**$25,452**	**$19,740**	**-5%**

Geographic Distribution of Respondents

WEST 35.1%
20 Respondents
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, Wyoming

CENTRAL 21.1%
12 Respondents
Illinois, Indiana, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin

SOUTHEAST 26.3%
15 Respondents
Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia

NORTHEAST 17.5%
10 Respondents
Connecticut, Delaware, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

NOTE: 1995 salaries are as reported in the survey. For comparison, 1987 salaries were converted to 1995 dollars in the course of calculating percent changes.

Regional Salary Variation

	Executive Director	Admin Director	Operations Manager	Div Ops Supervisor	Field Supervisor	EMT Paramedic	EMT Basic
West	$73,051	$60,285	$59,753	$48,897	$39,247	$34,525	$29,705
Central	83,280	47,133	53,850	47,866	36,414	30,818	27,106
Southeast	64,178	45,535	47,903	40,520	33,381	28,204	24,555
Northeast	61,667	55,591	50,508	44,083	36,933	28,910	20,873

Employee Benefits

Salary is only part of the compensation package that employers must offer in order to retain personnel. Escalating health care costs have resulted in an increasing importance of benefit packages. In contrast to U.S. trends, the number of EMS employers offering major medical continues to rise. This year, 100 percent of the respondents reported they had paid either all or some portion of major medical coverage.

Also noteworthy in this year's findings was an apparent reduction in the number of employers providing a retirement or pension plan, and an apparent increase in those offering some form of profit sharing. These changes may reflect the larger percentage of private providers in this year's sample. Finally, the number of employers offering shift differentials appeared to be one-half of what was reported in 1994.

Who Responded to This Survey?

The number of surveys distributed this year was consistent with previous years. Of approximately 150 surveys mailed, 60 were returned, for a response rate of 40 percent. This response rate was lower than in previous years, however, the distribution of respondents in terms of region and provider type remained relatively unchanged. For this reason, *JEMS* remains confident that the results are consistent with industry activity.

As in past surveys, efforts were directed toward obtaining a consistent sample of providers responding to a standardized questionnaire. The sampling methodology was designed to identify and monitor annual changes in the same sample each year. However, the present level of consolidation created a formidable roadblock to getting the survey to the most appropriate location for completion.

This year's salary survey continues to track salary trends. It was designed to serve as a barometer of compensation activity and as tool in preparing appropriate compensation packages. As changes in sample size, demographics and other variables influence the results from year to year, reliance on the absolute numbers in this report may be misleading. However, combined with other relevant industry data, the salary survey serves as a point of reference in which to negotiate.

This survey was conducted and analyzed by Emergency Care Information Center (ECIC), a division of Jems Communications. For the complete, detailed salary survey report, send a check for $25—payable to Jems Communications—to Geoff Cady, Research Director, ECIC, P.O. Box 2789, Carlsbad, CA 92018.