RISKING EVERYTHING

EMTs, Universal Precautions, and AIDS

BY WENDY J. HELLINGER, MA AND
SHERYL M. GONSOULIN, BSN, MN

IN 1981, AMERICAN HEALTH PROFESSIONALS CAME FACE TO FACE WITH A PREVIOUSLY unknown and invariably fatal, infectious disease. Because it was first found predominantly among gay men, the disease was called gay-related immunodeficiency disease (GRID). Thirteen months and more than $1 million in research later, the Centers for Disease Control and Prevention (CDC) dropped the term GRID and changed the name to acquired immune deficiency syndrome (AIDS) to reflect the fact that this new plague wasn't just a disease of gay men: heterosexual men, women and children were dying, too. Since 1981, AIDS has claimed the lives of a quarter million Americans. Today, the World Health Organization estimates that as many as 15 million people worldwide may be infected with the human immunodeficiency virus (HIV).[6]

The face of AIDS has continued to change: For the past four years, the number of women, children and ethnic minorities diagnosed with the virus has increased and the incidence of infection in bisexual and homosexual men has decreased. Experts predict that by the

formance indicator system.

• **The Peer Driven Quality Improvement Committee** is made up of front line paramedics and firefighter EMTs who provide direct patient care. Both management and the organized labor unit have selected members. This committee establishes standards and department benchmarks, recommends solutions for problems and researches and develops improvements in patient care. The committee makes recommendations for action each month and has yet to be turned down on any of its recommendations. The chief of operations sends policies to this committee for review before implementation. In several instances, the committee has said the policies were not workable, and they were either dropped or rewritten.

Quality Checklist

It's an overwhelming task—trying to summarize what makes this department so extraordinary. Still, a few things stand out in the SCFD system:

• The leaders have a clear sense of their department's purpose. "In our organization everyone has two jobs: they are cross-trained in both fire and EMS. Our EMS department happens to put out fires on the side," says Chief John Albritton.

• Based on a commitment to learning and development, Sarasota regularly provides training in customer service, leadership and quality management. According to Deputy Chief Julius Halas, "We have provided training for everyone called 'Voice of the Customer.' We call our new initiative for all county leaders 'Building the Foundation of Trust'."

• The department works as a team, focusing improvement efforts on system—not individual—performance. "Eleven years ago when I was a medic, I could see the system problems," says Gorski. "I decided that if I ever became a manager, I wasn't going to ignore system issues. I can't think of a situation where we have taken the data collected in quality improvement to an individual level. We have too many system improvements to make before we could think of doing that."

• Sarasota remains conservative with its data management. Rather than measuring everything, it focuses on 14 key performance indicators, which the department tracks daily and reports to everyone. They maintain a direct link between the key performance indicators and the training and recognition programs.

• Its labor management relationships stand as exceptional and both parties insist that everyone must remain involved in service improvement. "Every system has lots of talent that it should tap," says Gorski. "It's essential to listen to people who are out doing the work. Listen to the issues they identify and help them design their own solutions. You have to realize that you can't do all the work yourself." Indeed, as one EMT firefighter put it, "This department expects crews to initiate. We design our own rigs. If we need something, we ask. If we can justify it, the department never turn us down. This is the best job in the best department in the world."

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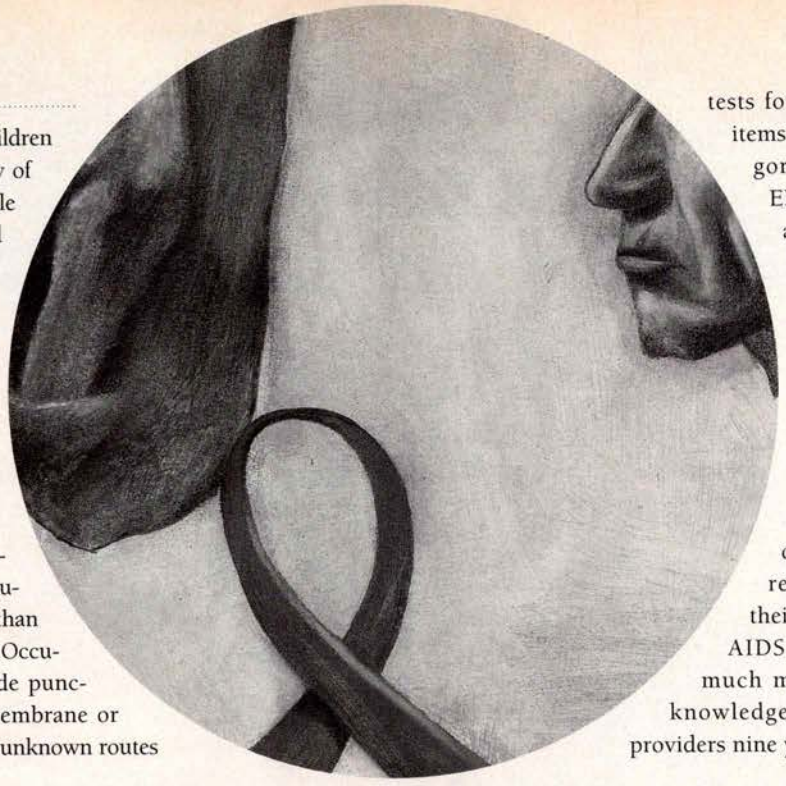
For more information about Sarasota County Fire Department's Quality Program, contact Quality Improvement Manager David Harrawood, 914/316-1374.

year 2000, women and children will constitute the majority of AIDS patients. As the circle of infection widens and more effective treatments become available, the geriatric population infected with HIV will also increase.[6]

What does this mean for EMS providers? The CDC reports that at least 52 health care workers in the United States have contracted HIV following occupational exposure; more than 24 have developed AIDS. Occupational exposures include punctures or cuts, mucous membrane or skin spills or splashes and unknown routes



tests for differences in response items among professional categories (first responder and EMT- Basic, -Intermediate and -Paramedic), age, gender, years of service, type of service (private, parish, municipal, fire), population served (urban, suburban, rural) and paid or volunteer providers.

Results

More than 70 percent of survey respondents reported satisfaction with their level of education about AIDS. Respondents reported much more confidence in their knowledge of AIDS than did EMS providers nine years ago,[5] suggesting that

PEOPLE WHO WERE IN EMS PRIOR TO THE ONSLAUGHT OF THE AIDS MENACE ARE LESS CAUTIOUS THAN THOSE GETTING INTO THE FIELD TODAY.

of exposure. The majority of infected health care workers were exposed to blood or bloody body fluid. In addition to these cases, the CDC knows of 114 cases of HIV infection or AIDS among health care workers who appear to have contracted HIV through occupational exposure, but whose exposure was not documented.[3] In fact, the true number of health care workers who have contracted HIV through occupational exposure remains unknown. EMS personnel are routinely exposed to HIV. Unless they adhere to universal precautions with every patient, more EMS personnel will become infected as "likely" HIV carriers become increasingly difficult to identify.[2]

To assess attitudes toward HIV-positive patients, satisfaction with their level of knowledge about HIV infection and compliance with universal precautions, a 15-question survey was administered anonymously to a sample of EMS providers in a Southeastern state. The questionnaire was based on the tool used in a study conducted in 1989 by Scott Matin and David Lester to investigate the attitudes of EMTs and RNs toward AIDS. Respondents were asked to report:

- how satisfied they were with their knowledge about HIV-infection,
- their attitudes about HIV-infected patients,
- their perceived level of risk of contracting HIV through EMS practice,
- to what extent they adhere to universal precautions.

Data were analyzed using frequency tabulations and statistical

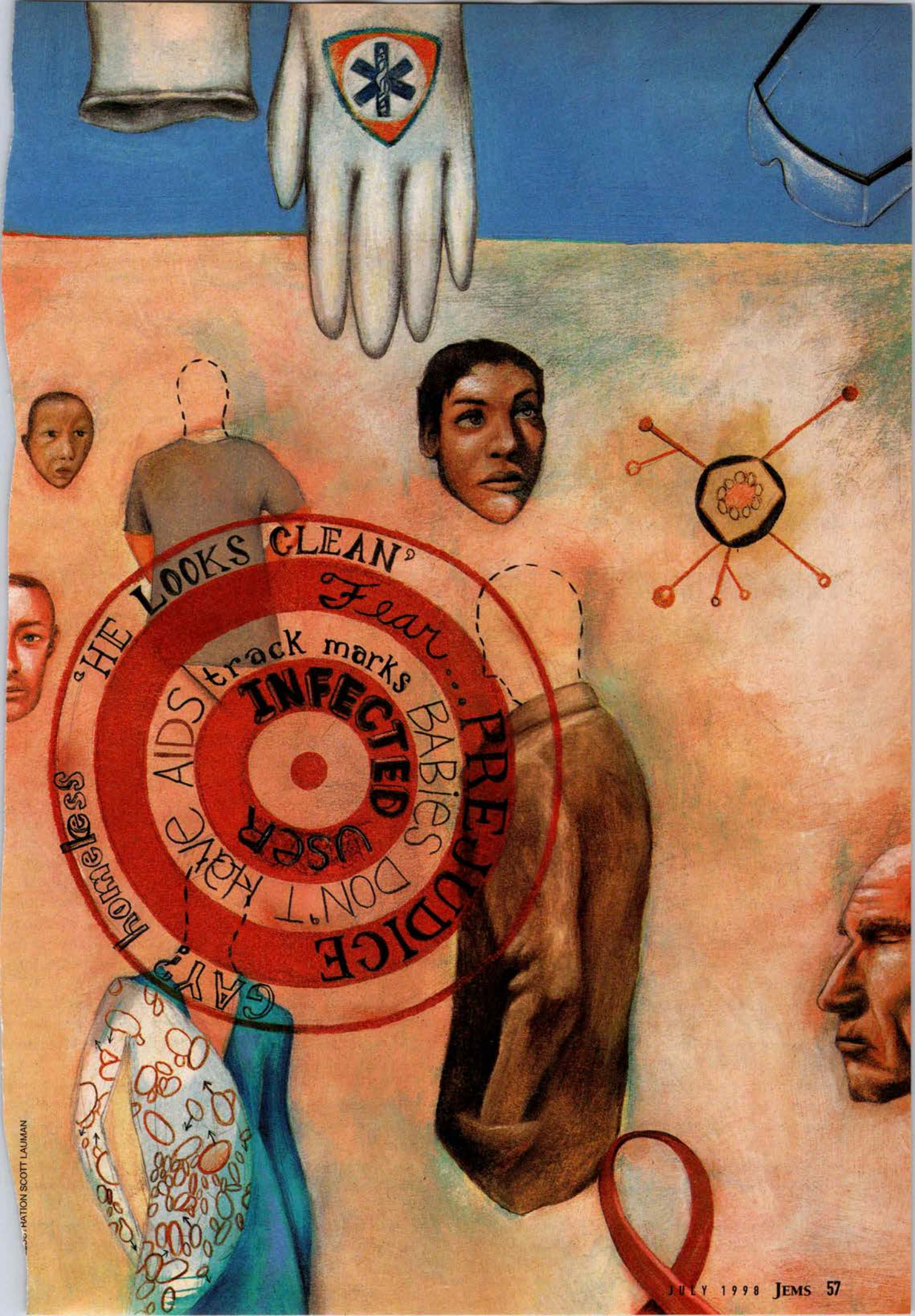
most EMTs and paramedics now have sufficient access to education and literature about AIDS.

A 70 percent majority of those surveyed said that they do not believe there is discrimination against AIDS patients in EMS, and an even greater number (78 percent) claimed they do not treat AIDS patients differently from other patients. Ironically, almost nine out of 10 (89 percent) agreed or strongly agreed with the statement "I should have knowledge of AIDS patients prior to treating them," implying that they would alter their professional behavior if they knew a patient was infected.

Survey participants also responded to questions on exposure risks specific to EMS. Four out of five respondents felt that EMS providers have a greater chance of exposure to HIV than others in the health care field. One third of those surveyed indicated they disagreed or strongly disagreed with the statement, "My employer is doing everything possible to protect me from being exposed to HIV."

Eighty-eight percent reported that they "always follow the recommended protocols to protect [themselves] against AIDS (i.e., universal precautions)." This means at least 12 percent of those who answered the survey do not consistently adhere to universal precautions with every patient, occasionally leaving themselves unprotected from potential occupational exposure to HIV infection.

Why would EMTs risk everything—even their lives—when HIV remains fatal for all those infected? Following universa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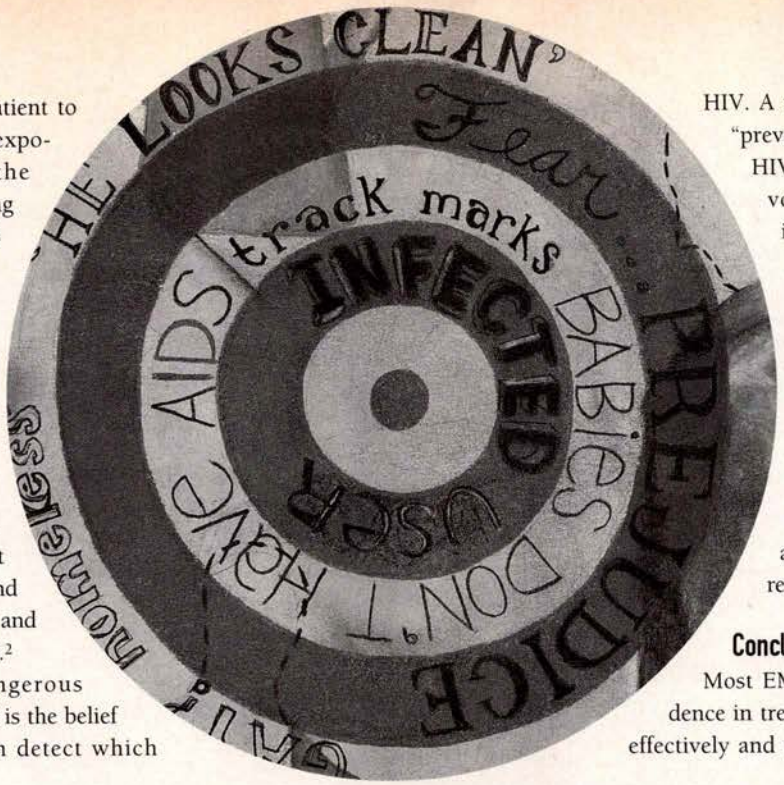
precautions with every patient to protect against possible exposure to HIV also has the corollary benefit of helping to protect the EMS provider against other occupational risks, such as hepatitis.

Some research suggests that EMS personnel remain less informed than they think they are. One study concluded that myths and misconceptions about transmission of HIV abound among EMS, public safety and law enforcement personnel.[2]

One of the most dangerous myths frequently reported is the belief that field personnel can detect which patients are HIV-infected and that they only need to follow universal precautions with patients so identified. This comprises a senseless gamble: Many HIV-infected patients have no symptoms, do not fit the stereotypical image of the AIDS patient, and may not even know that they are infected.



In a revealing study conducted at Johns Hopkins University in Baltimore, Md., 28 percent of seropositive, randomly tested emergency room patients over age 14 were unaware of their own HIV-positive status; more than a quarter did not fit the traditional profile of the AIDS patient (i.e., 17 percent were black males, 8.5 percent were black females, 2 percent were white females).[4]

No one can identify a majority of the HIV-infected patients by casual observation: Only a blood test, unavailable and inappropriate in the field, can reveal an HIV-infection. Even among populations generally at low risk of HIV seropositivity, exceptions exist. Patients infected with HIV include infants, toddlers, school-age children, pregnant women, middle-age men and women and senior citizens. We treat patients infected with HIV from city apartments, suburban shopping malls, farms and retirement homes.

Despite the risks, and consistent with the results of the 1989 survey, EMS personnel are not interested in changing careers because of the threat of contracting HIV. More than 80 percent of the respondents to the 1997 survey indicated that they would not consider a career change because of the professional risks of contracting the virus. Yet these dedicated professionals continue to avoid practicing behaviors proven to help protect them from contracting HIV. A recent article pointed out, "preventing the transmission of HIV requires that individuals voluntarily change behaviors"[7]. Safer behaviors are as essential to EMS personnel in professional practice as to private citizens in sexual practices.

Unless EMS workers consistently follow universal precautions with every patient, preventing the transmission of HIV among EMS providers will remain a serious problem.

Conclusions

Most EMS providers report confidence in treating HIV-infected patients effectively and without bias. Many of the HIV-infected patients encountered are children, minorities and heterosexuals.

Although the majority of EMS providers believe they should be informed of a patient's seropositivity, many infected patients remain unaware that they are HIV-positive and are asymptomatic. EMS personnel must consistently follow universal precautions with every patient to reduce the likelihood of contracting the virus.

MANY EMS PERSONNEL MISTAKENLY BELIEVE THEY CAN DISTINGUISH HIV-POSITIVE PATIENTS BY CASUAL OBSERVATION.

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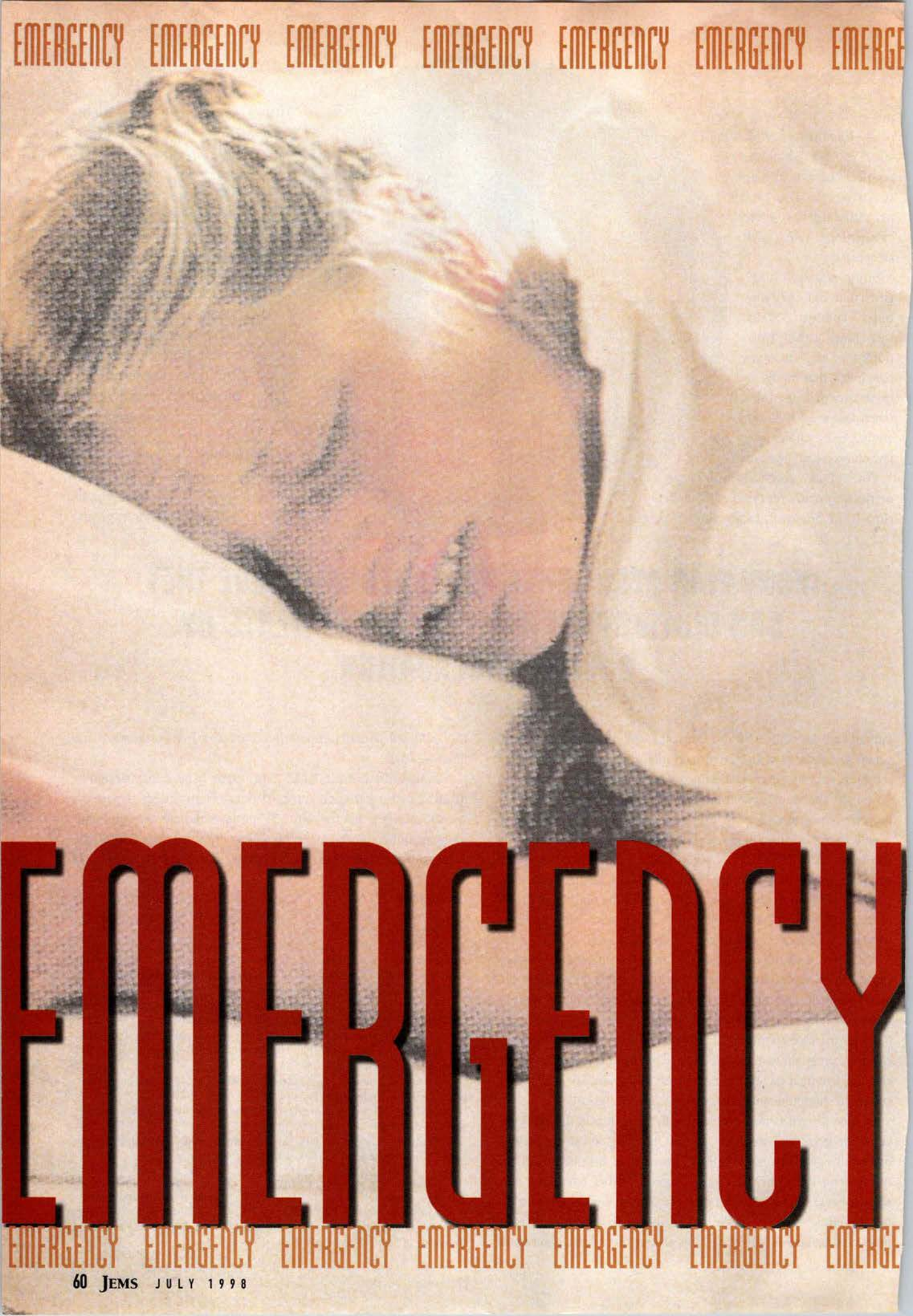
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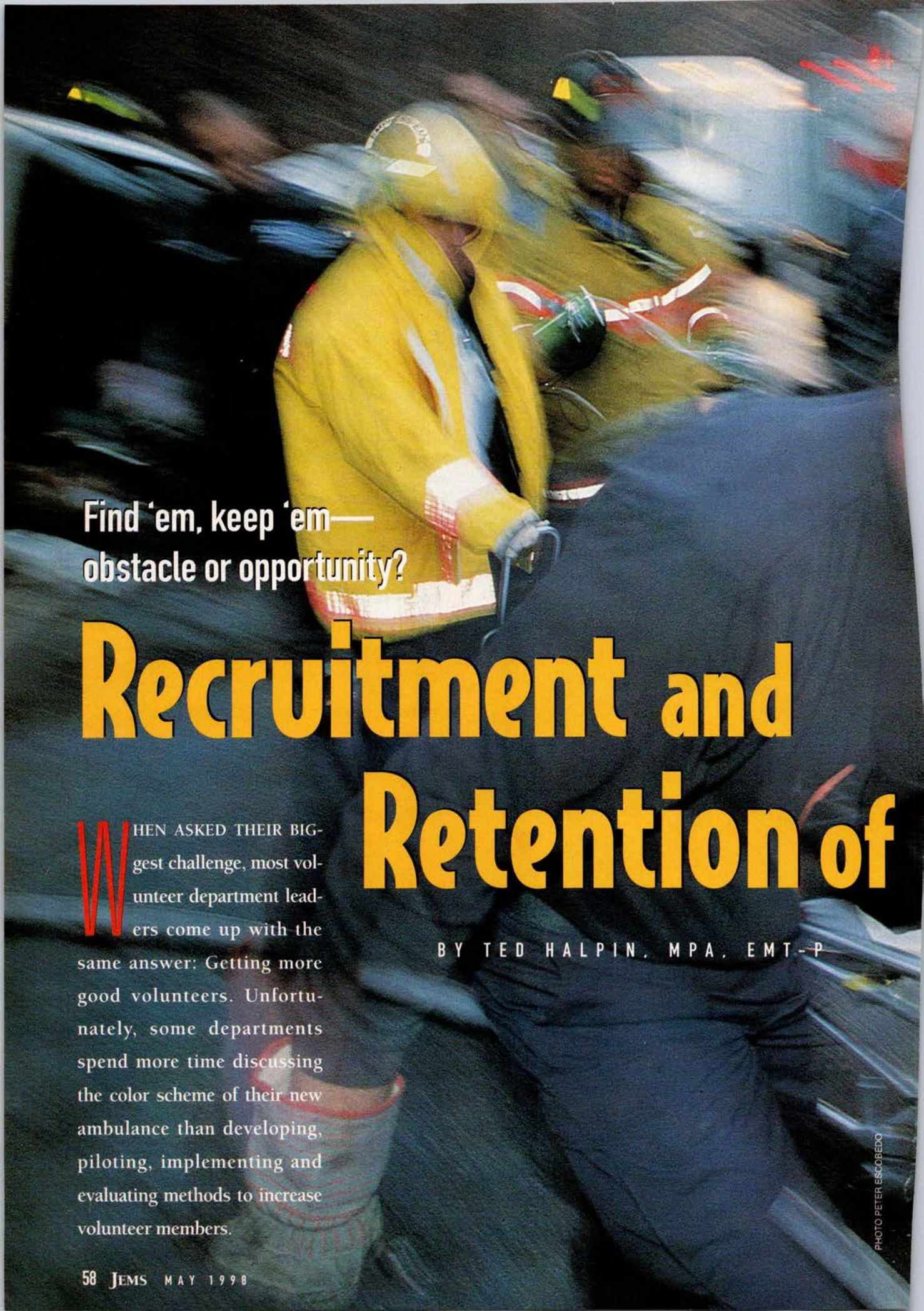


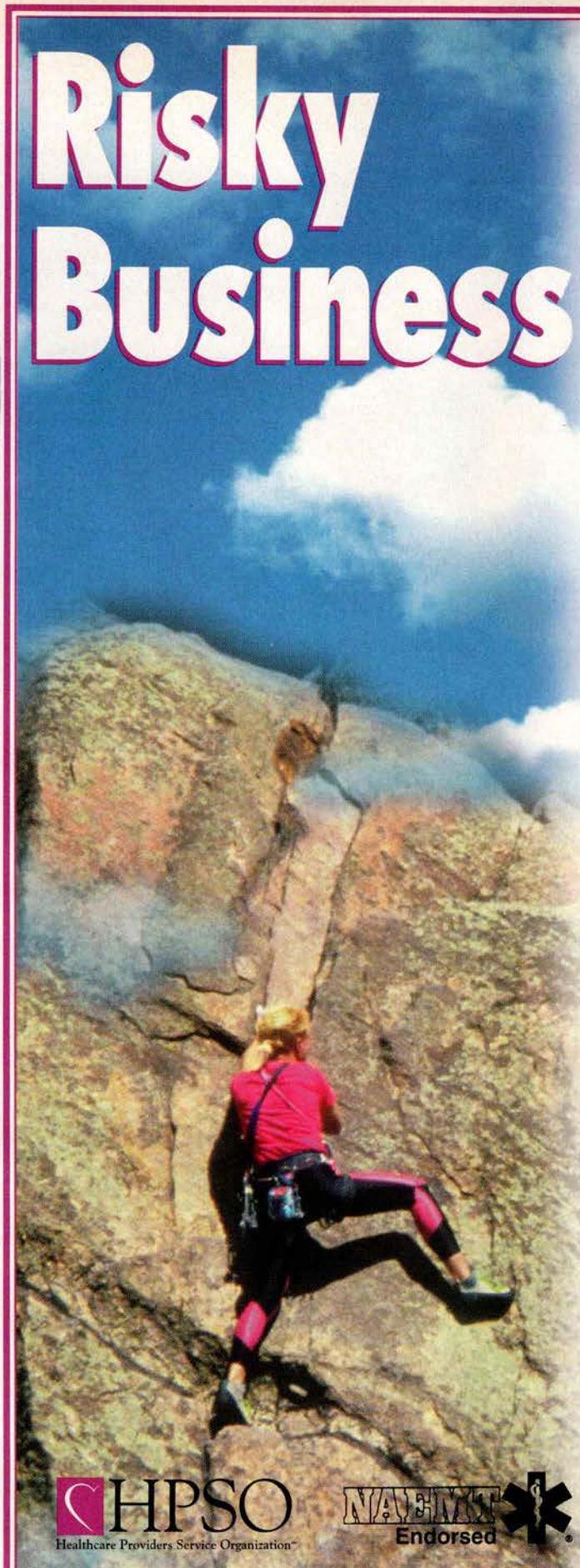
Find 'em, keep 'em—obstacle or opportunity?

Recruitment and Retention of

BY TED HALPIN, MPA, EMT-P

WHEN ASKED THEIR BIGgest challenge, most volunteer department leaders come up with the same answer: Getting more good volunteers. Unfortunately, some departments spend more time discussing the color scheme of their new ambulance than developing, piloting, implementing and evaluating methods to increase volunteer members.

PHOTO PETER ESCOBEDO



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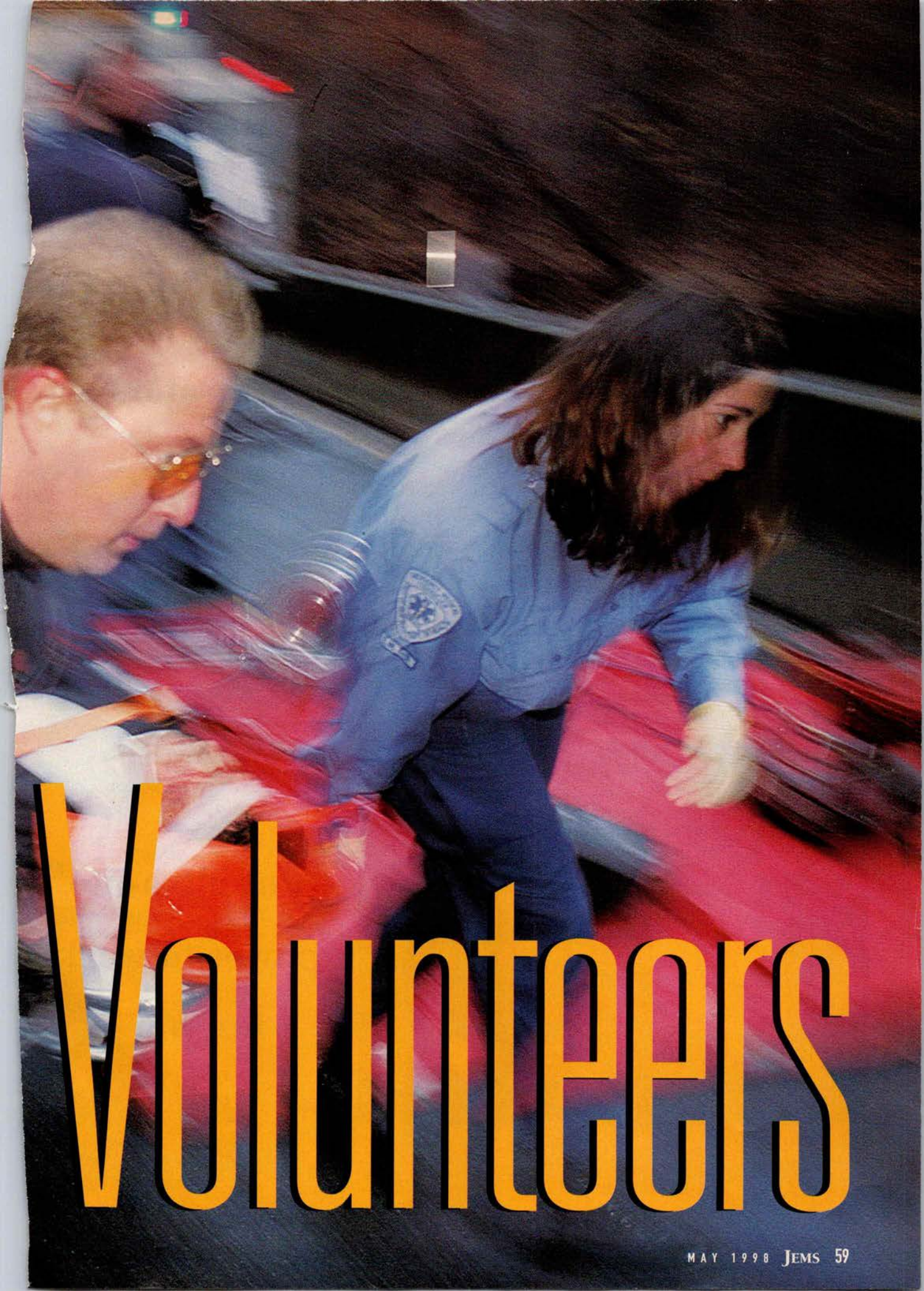

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customers who were impressed with the department and its members. Departments should provide business cards for their members for spontaneous recruiting. Some services provide recruiting rewards to their members.

Have a Plan

A sudden loss of personnel triggers some recruitment efforts. Typically, a department prepares a recruitment notice for the local newspaper. But even if the notice successfully attracts attention, the department has no plan to follow.

Frequently, potential recruits are directed to a department member for more information. Then, an informal meeting occurs at the EMS station, a critical point in the recruitment process. The recruit often decides at this time whether or not to associate with the department. These meetings often have little structure to them, which can result in the delivery of inconsistent messages to the recruits.

Recruits who receive a confusing or incomplete message will hesitate to fill out the membership application. If the recruit gets a hurried member or one who has had a bad day at work, they can easily get turned off and shop around for a service that presents a better attitude or environment.

Recruitment would be a non-issue in many departments if they had good volunteer retention programs.

The First Few Weeks After Someone Applies

Services need to evaluate how long their membership approval process takes. Long delays create a sense of uncertainty and may cause the new member to wonder whether the organization needs them. Organizations must strive to make their recruitment process as smooth as possible.

For those recruits who sign on, the first few weeks are critical. Make orientation and training available and convenient for the new member. For example, recruits should not be asked to drive 40 miles to a training class or told there won't be a basic CPR class during the first three months. Run one or find one nearby to keep them interested.

Let's look at three elements critical to the success of a department's recruitment process: planning, selling and closing the deal.

Planning includes: 1) an internal analysis of the department and its needs; 2) an analysis of the community; and 3) the preparation and testing of the message you wish to convey to the community. Selling comprises the delivery of the message to the community and any

Recruitment would be a non-issue in many departments if they had good volunteer retention programs. In some departments, leaders have even given up on recruiting. They think they've exhausted their community of volunteers. Unfortunately many volunteer leaders today fail to realize that they control their department's destiny.

Your biggest asset can be existing personnel who are willing to assist in your recruitment and orientation processes.

Community Support

Volunteer recruitment is unquestionably linked to community support. Typically people do not join organizations they believe stand on shaky legs or have poor reputations. Just like any other business, volunteer services must pay attention to their image in the community and keep their agencies in good standing. Organizations should adopt and maintain high ethical standards. One bad newspaper report can set recruitment efforts back 10 years.

Utilizing Active Members in Recruitment Efforts

Other than a service's community image, the recruiting efforts of active members have the greatest impact on attracting new volunteers. People like to work with individuals who have integrity and understanding, competent, compassionate people committed to a worthwhile cause. So we should take every opportunity to portray volunteers in a positive light. Often, recruits are recent

targeted individuals and groups. Closing the deal includes the enrollment and orientation components of the process. Combined, these three elements will ensure successful recruiting.

Planning: The Department Analysis

The recruitment planning process must begin with an analysis of the department and the community. A department must determine how many members it needs to effectively and efficiently operate on a 24-hour basis, based on success and failure in the previous recruitment efforts and how it will use available funds to maximize recruitment efforts.

The department analysis should result in the development of several resource materials: 1) a one-page fact sheet about the department; 2) a booklet that describes the department in greater detail; 3) a new member algorithm to track each prospect; 4) a checklist for department recruiters to use in interviews and 5) a job description (written requirements and expectations) for each needed position.

The fact sheet should list the department's mission, responsibilities, methods, needs and list of telephone numbers or schedule of open houses. Distribute informational sheets at meetings, during open houses, in Welcome Wagon packets, through other community groups and by department ambassadors, who speak at community gatherings.

The booklet needs to provide a detailed description of the department. It should include a history, member requirements, training opportunities, membership benefits, application process, a calendar of events and training sessions, child-care opportunities and testimonials from customers, patients, physicians. Make it available to anyone who responds to your initial recruitment for new members and to individuals who express an interest in your service. This booklet ensures that a complete, consistent message to potential members.

Departments must do everything possible to streamline their application process.

A new member checklist (see page 71) provides a road map for the department to track the status and progress of applicants. This will keep the membership process moving forward and assist the new recruit in understanding the application process. Departments must do everything possible to streamline their application process.

Checklists serve as reminder sheets for service administrators and training staff. In particular they help department members who have the first contact with new personnel. A checklist is helpful for use either on the telephone or

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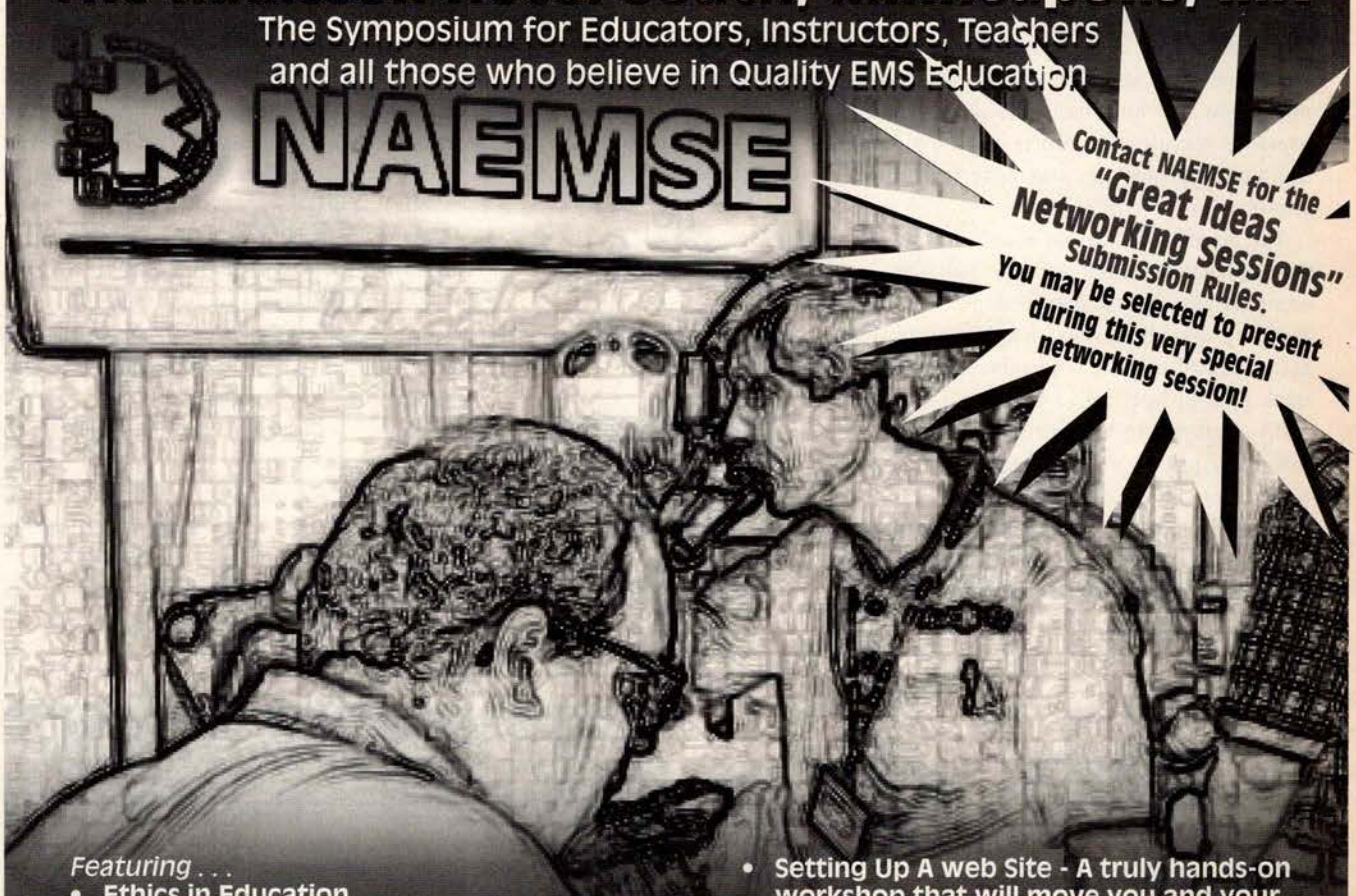

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during the initial meeting with potential members. You can also use them to help existing members outline the membership process during recruiting activities. Checklists serve as another means of ensuring that you communicate an appropriate, consistent message to new recruits.

Write job descriptions for each position recognized within your organization. Job descriptions provide potential members with an idea of the tasks, reporting structure and evaluation processes that exist in your service.

Finally, your department should prepare and distribute only high quality documents—not third generation copies. Documents that show faded text, off-center images or copy riddled with spelling and grammatical errors reflect poorly on your department and send a bad message to the reader about your service's quality and professionalism.

Community Relations

Community relations have the most important impact on the recruitment program. For example, what community organizations would benefit from a department ambassador delivering the recruitment message? The department ambassadors might visit churches, synagogues, schools, civic groups, businesses, retired citizen groups and your local chamber of commerce, delivering the recruitment message and distributing your one-page informational sheet. You might also identify employers or community colleges throughout your service area for distribution of information sheets to their employees or students.

The community relations program should include the development of a media contact list to communicate your department's recruitment message. Include contacts from the local and school newspapers, radio and television stations, chamber of commerce, professional organizations, community newsletters and civic groups. Use posters, inserts in water and sewage bills, as well as grocery-store bag inserts for recruitment messages. County and state EMS or fire offices often have prepared artwork you can use in the design process.

When it comes to signs, bigger is better. Billboard space is often available for free as a public service to non-profit entities when a billboard customer's lease falls through and a temporary message must be put in its place. Your department will have to cover the expenses involved in the design, preparation and placement of the advertisement, but not the expensive monthly display charge. The same holds true for public service announcements on many radio stations.

Some volunteer departments use honorary memberships to solicit media and community attention to their department. For example, the fact that a well-respected resident of the community belongs to your department draws attention to the composition and quality of your department. Once you have prepared the department and community analysis, deliver the message; then sell it.

Selling

Selling your department to prospective

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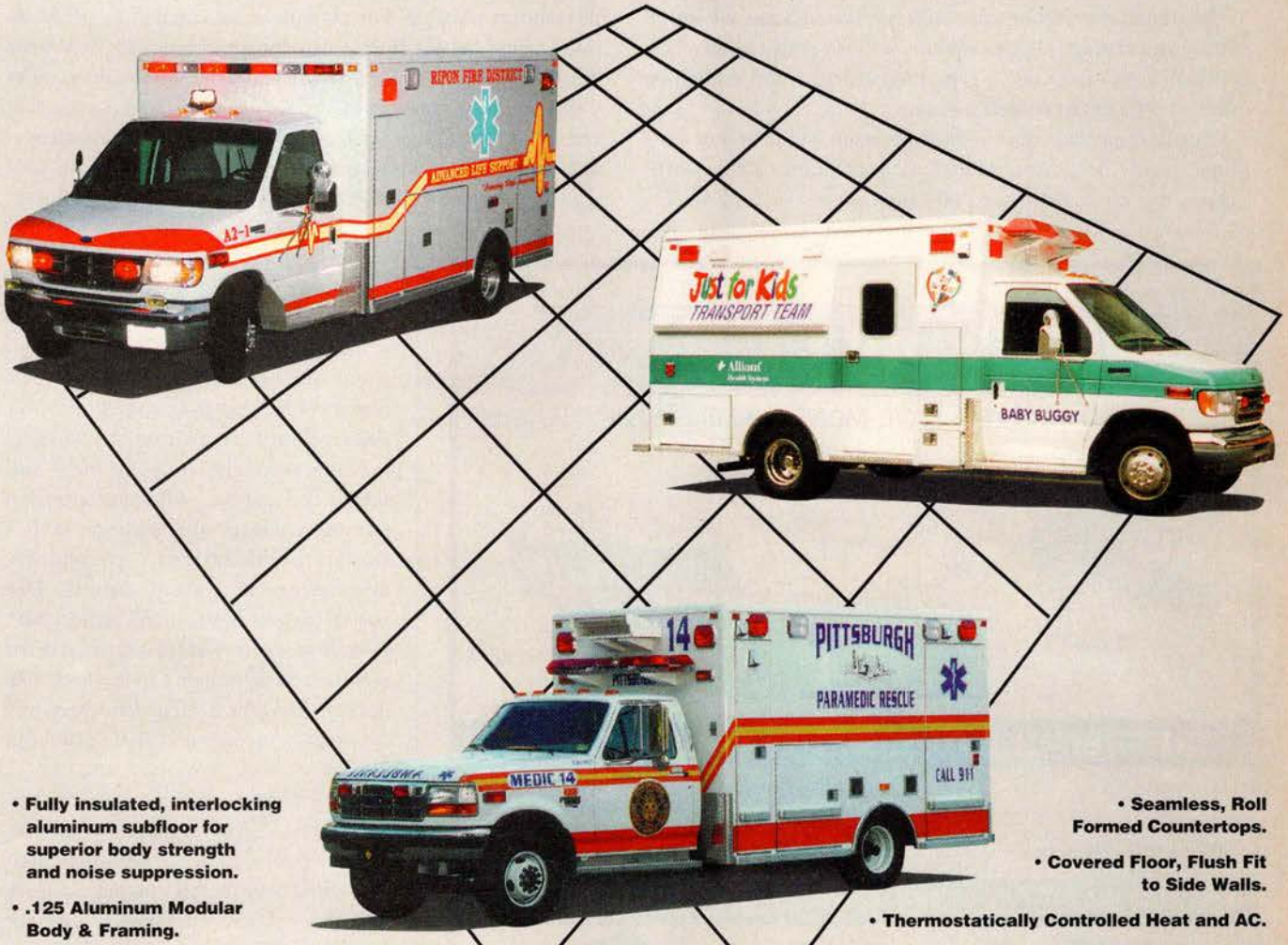

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members requires person-to-person contacts and group presentations. Person-to-person contact succeeds when you have a good plan in place, and your members are properly prepared. This common form of recruiting can be an effective means of getting your message across to the community.

For group presentations, the department should feature an accomplished speaker. Local groups may not expect an orator, but they will count on a well-prepared message. They will also prefer one delivered in a clear and concise manner.

Visual aids can enhance the delivery of your recruitment message. Piloting your presentations on small outside groups will prevent failure from occurring in front of a large targeted audience. Comb all handouts and slides for errors and clarity of the material.

Require the ambassadors you send on recruitment activities dress properly because they serve as the audience's first impression of your organization.

Retention begins the moment a new member signs on.

Closing the deal

Once you've delivered the message to the community, your department must know how to handle the prospects that result. The recruitment message must include a name and telephone number for prospects to call. Make every effort to ensure the availability of this contact

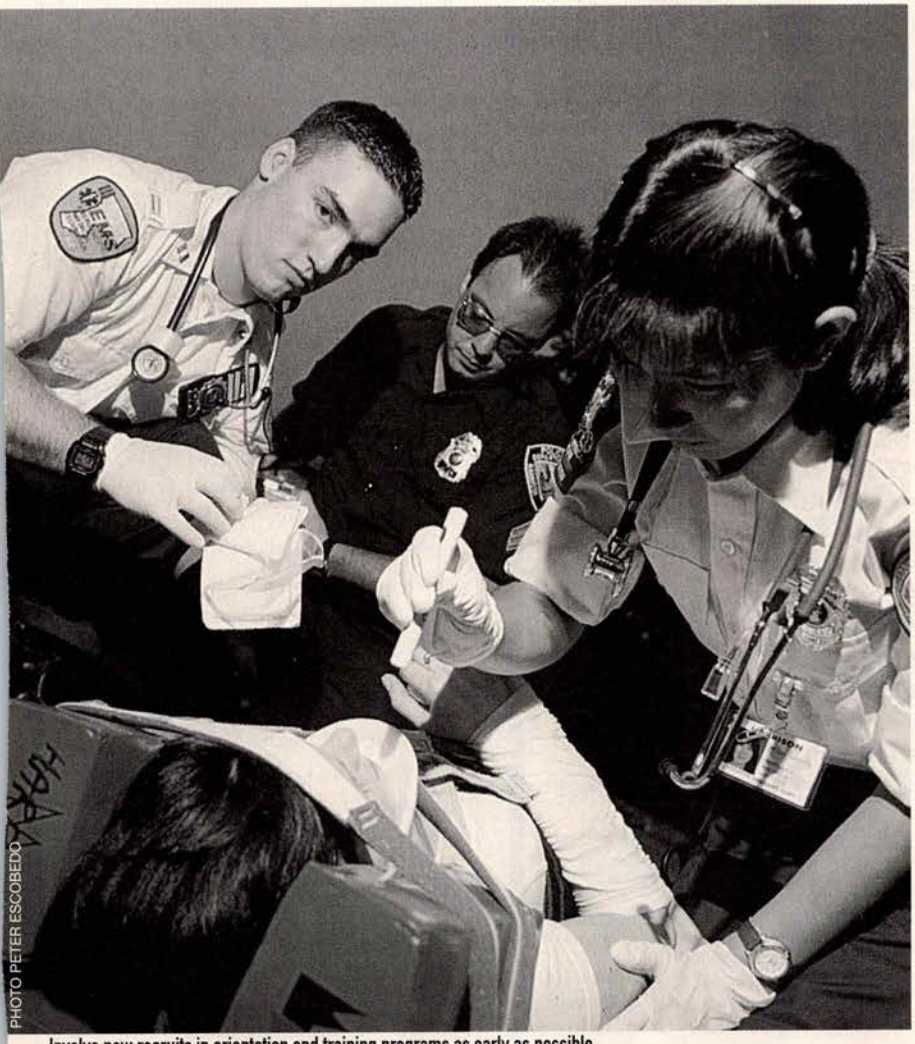


PHOTO PETER ESCOBEDO

Involve new recruits in orientation and training programs as early as possible.

during the times advertised. There's nothing worse than having an enthusiastic recruit call an answering machine, wait two weeks for a return call regarding their orientation or having them arrive at a station only to learn that the person assigned to show them around forgot the appointment.

The planning phase of the recruitment process should produce a simple worksheet for the department's contact person to use when taking a recruit's call. The initial telephone call should result in a concise conversation, which leads to the scheduling of an interview. The prospect's name, address, and telephone number must be correctly recorded, along with all previous training and experience. The prospect should also identify what department position(s) they are interested in. (EMT, first responder, paramedic, trainee, explorer scout, driver, support staff etc.). The recruit should receive a written confirmation within three days after scheduling, along with the prepared department materials.

The department should select the most appropriate member to conduct the interview. Whenever possible, base selection of the interviewer on, and complement, the prospect's interests and background.

The one-on-one interview should also have a pre-arranged structure and format. A checklist here will ensure the discussion of all important items. For effectiveness, conduct the interview at the department headquarters. Make sure the department headquarters sends the appropriate message: nothing but a clean facility will do. Some services contract with an outside cleaning service to keep their facilities in optimal condition. Volunteer staff remain responsible for assigned daily basic station and vehicle cleaning. The contracted cleaning service manages periodic housecleaning responsibilities.

Keep the interview informal, yet organized and free from interruptions or distractions. Frequently, an interviewer will do all the talking and overwhelm the prospect with a mass of information: Avoid this scenario. Stick to the established checklist and focus on what and how the recruit responds to your ques-

Volunteer Membership Checklist

	(circle one)		
	BLS	ALS	
1. Applicant Inquiry Name: _____ Address: _____ City, State, Zip: _____ Phone: _____			Date _____
2. Message to membership staff via phone or voice mail to immediately mail out pre-made packet (annual report, brochure, application, job description, etc.)	yes	no	Date _____
3. Packet mailed out next business day; cc: cover letter to operations and administration.	yes	no	Date _____
4. Seven days post-mailing—office calls to confirm receipt of packet and schedules interview	yes	no	Date _____
5. Application form received?	yes	no	Date _____
6. Copies of certifications and driver's license provided?	yes	no	Date _____
7. References provided?	yes	no	Date _____
8. Driving record provided?	yes	no	Date _____
9. Interview (assure completeness of application/qualifications/attitude, etc.)	yes	no	Date _____ (no more than 5-7 days from original applications)
10. Second interview required prior to observing?	yes	no	Date _____
11. Contacted and scheduled to ride (observer) time?	yes	no	Date _____ (no more than 3-4 days from above)
12. Initial observation (orientation of vehicles, review SOGs, forms, etc.). Forms—orientation of vehicles, etc.	yes	no	Date _____
13. Contacted explaining status (acceptance or additional expectations).	yes	no	Date _____ (no more than 10-14 days from above)
14. Comments—explain delays, needs, etc. _____ _____ _____			Date _____
15. Acceptance decision. Comments:	yes	no	Date _____ (no more than 30 days from application date)
16. Set up follow-up evaluation reviews.	yes	no	Date _____ 30/60/90 days from above

tions. Active listening includes the overall assessment of the prospect's background, desires and needs.

The interview checklist should include a question that specifically asks and documents the prospect's intentions in applying to become a member of your service. If the response is favorable, then the interviewer may proceed. Once the recruit expresses the intent to sign-on and join the organization, the department must follow through to complete the application and enrollment process. This phase includes reference and criminal history checks, as well as the verification of certificates and applicable motor vehicle operator licenses.

In some organizations, the period between the prospect interview and membership enrollment is too long. This elicits feelings of doubt from the recruit about whether the organization needs or finds them acceptable. Make every attempt to involve the recruit immediately in department activities. Never place them in an ambulance or rescue vehicle on calls prior to a formal orientation; however, you may appoint them to a committee or enroll them in orientation and training.

Many departments successfully use a buddy system that pairs the recruit with an existing member familiar with the structured orientation program. This can enhance the orientation for the new member and boost their enthusiasm.

Many departments believe they've won the battle when new people are enrolled. But *retention* of quality members may be the most important job in managing volunteer departments.

Elements of Success

The success of any recruiting process depends on planning, selling and closing it. Too often, volunteer departments spend a limited amount of time and effort in these areas. This results in low membership and increasing responsibility for existing members, which eventually leads to the loss of good members.

Retention begins the moment a new member signs on. Many departments make the mistake of believing they have won the battle the moment new people are enrolled. Actually the retention of quality members may be the most important job in managing today's volunteer department.

Ted Halpin is executive director of Ontario County Advanced Life Support, an affiliate of the F.F. Thompson Health System in Canandaigua, NY. He has 20 years of volunteer EMS and fire experience.

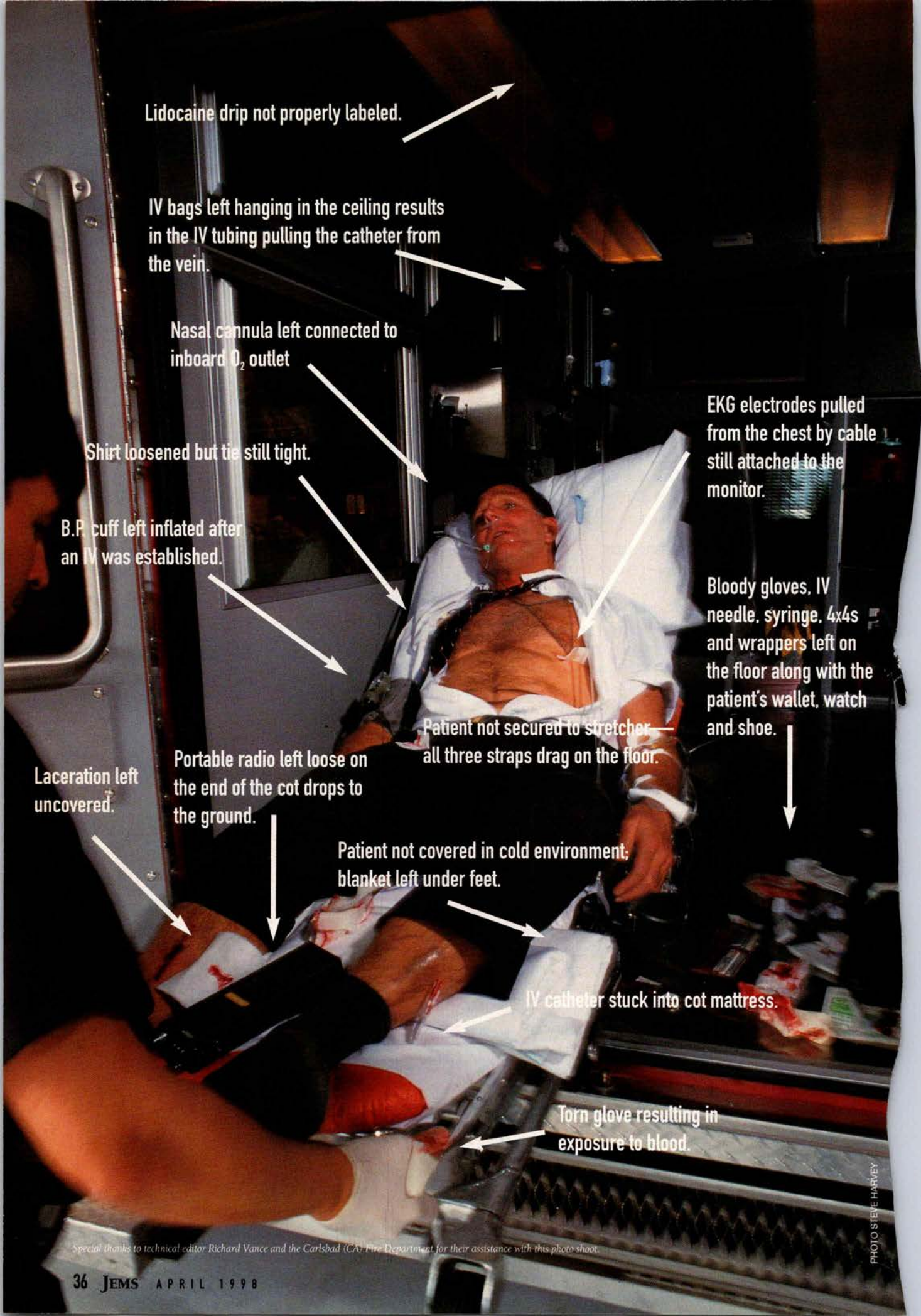


PHOTO STEVE HARVEY

Special thanks to technical editor Richard Vance and the Carlsbad (CA) Fire Department for their assistance with this photo shoot.

at lower energy levels. This paper reports on the first 100 victims of out-of-hospital cardiac arrest in systems using biphasic defibrillators. The study was conducted in 12 cities and involved flight attendants, police officers, EMS providers and ambulance physicians.

Forty-four of the 100 patients presented in ventricular fibrillation and were subsequently defibrillated. Successful defibrillation was achieved in 39 of the 44 (89 percent) patients on the first shock. Return of spontaneous circulation was achieved in 19 patients.

On the surface, study results suggest that biphasic defibrillation is an improvement over traditional defibrillation. There are, however, limitations to this study. First, successful defibrillation was defined as "an organized rhythm or asystole for five seconds post-shock." Even in the absence of a pulse, the presence of a non-viable rhythm, such as an idioventricular rhythm or the reoccurrence of ventricular fibrillation, the shocks were counted as successful. A second limitation "is that a concurrent comparison with a high-energy waveform AED was not made."

While this study demonstrates the technical utility of biphasic defibrillation, clinical studies with realistic definitions of success and blinded comparisons to traditional defibrillation should be completed before use of this technology becomes commonplace.—LHB

Prehospital Care: Between a rock and a hard place

Narad RA: "Economic regulation of ambulance services in California." *Prehospital Emergency Care* 1997; 1:253-258.

While this paper would be far easier to read if you were an economics major, it provides interesting insights into how prehospital care is caught in the middle of the public and private sectors.

The author surveyed California's local EMS agency regulatory programs to determine how they were applied and to identify differences around the state. California's statute on franchising ambulance services has been in place more than a decade. The survey achieved a 100 percent response rate.

Seventy-three percent of California counties use economic regulations. Counties that have large populations and operate their own local EMS agencies more frequently use economic regulations than small counties with multi-county EMS agencies. While the authorizing statute has a preference for competition, most franchises were granted without competition to existing providers. Most franchises in the state were granted to public services. The author points out there is a lack of regulation of ambulance services that have received what are (in effect) monopolies. The survey also found that the majority of ambulance rate-setting occurs outside of a competitive process.

The paper has a fascinating discussion of how local governments may interface with managed care organizations. The author concludes that regulations are often used to protect existing providers, especially public service providers, from competition. He also concludes that the competitive process may be compromised by increasing interest from the fire service in providing ambulance service, because there is already a bias toward them in granting franchises.

This should be required reading for EMS administrators. For the EMT/Paramedic, I'd recommend going straight for the discussion section of this paper.—RCH

Hunt, Brown and Prasad are affiliated with the Department of Emergency Medicine at East Carolina University School of Medicine in Greenville, N.C. Allison is affiliated with the Center for Emergency Medicine in Pittsburgh. The authors publish the EMS Journal Club, *a quarterly written and audiotaped review of research papers that have an impact on EMS. For more information, write to the EMS Journal Club, 2462 Stantonsburg Road, Suite 225, Greenville, NC 27834.*

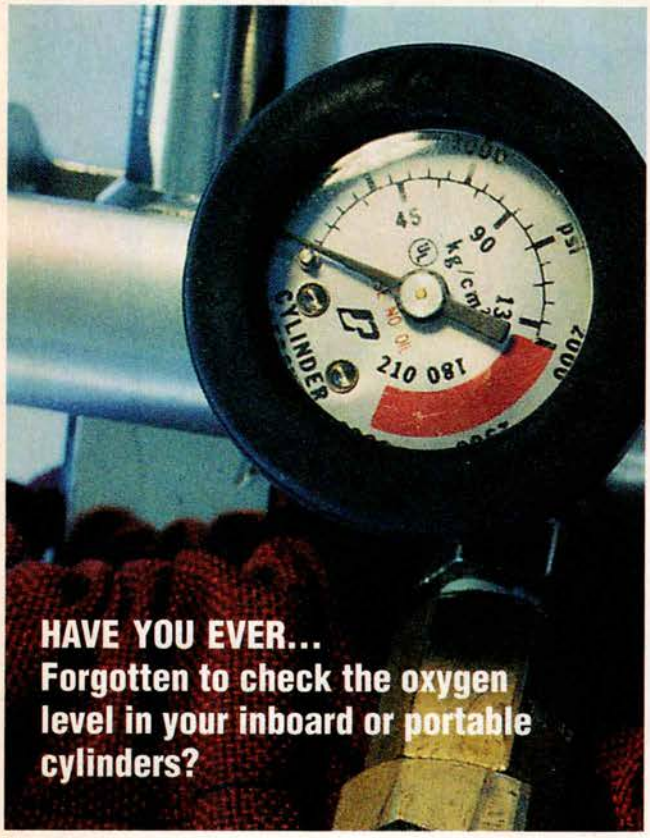
Oops! EMS MISTAKES—

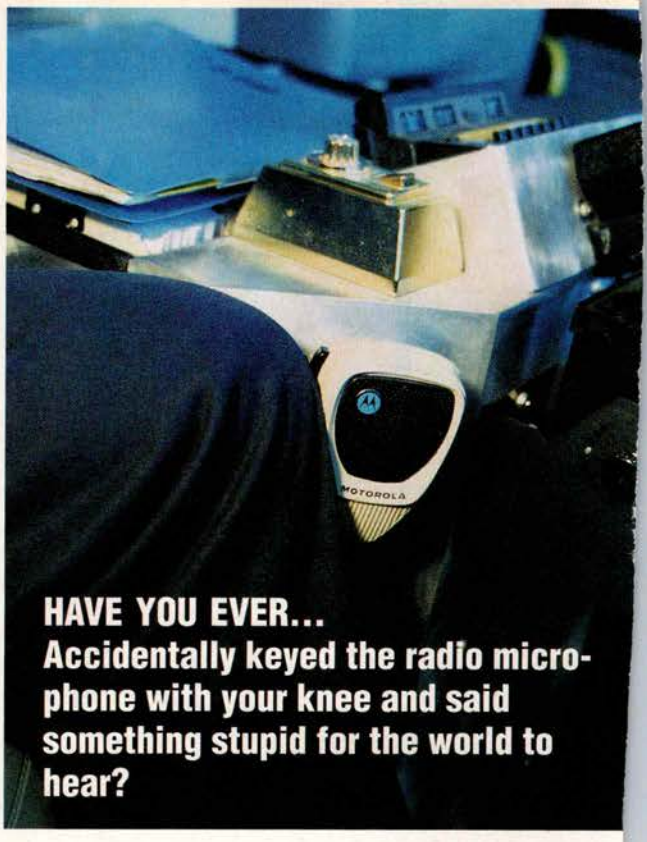
They're inevitable, stressful, painful and oh-so educational. This guide helps you classify them and avoid sweating the small stuff.

BY PAUL MURPHY AND MIKE TAIGMAN

MORTIFIED BY NEWS HE RECEIVED ABOUT A PATIENT HE HAD treated hours earlier, the new paramedic choked out an explanation: "*First responders were doing CPR when we arrived. The patient was in v-fib. I was wearing a short-sleeved shirt, and it really didn't seem that cold out. We shocked him and got a pulse back for 10 seconds or so, but then he'd go back into fib. Must have shocked him 30 times. We gave him full doses of lidocaine, bretylium, epinephrine, bicarb and Inderal. And now you're telling me he was hypothermic? Oh man, ... my career is over.*"

Unlike other professions, EMS holds little room for error.





Unlike other professions, EMS holds little room for error—our mistakes can result in death. Need proof? Here's a range of what can happen when EMSers slip up.

SERIOUS, LIFE-THREATENING MISTAKES:

- The unrecognized esophageal intubation;
- The IV catheter placed in the radial artery, causing hemorrhage and an inability to administer thrombolytics;
- Leaving a high concentration O_2 mask on the face of a critical congestive heart failure patient and forgetting to connect the tubing to the inboard oxygen port;
- Failure to transport a 24-year-old diabetic with the "flu" who later dies;
- Leaving contaminated sharps in your drug box—resulting in a needle stick to an EMT.

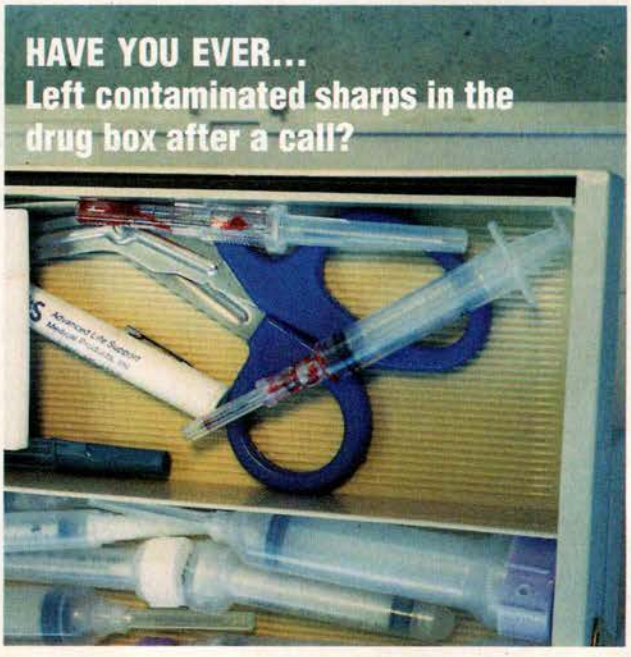
SERIOUS, BUT NOT NECESSARILY LIFE-THREATENING, MISTAKES:

- Forgetting to write down a patient's medications; failing to take the meds to the hospital;
- Forgetting to check the oxygen level in the main cylinder at the start of your shift;
- Telling a patient with a minor injury that Medicare will cover the bill—when it doesn't;
- Accidentally keying the radio microphone with your knee while describing how much you hate your supervisor.

Almost every EMS provider reacts differently when he or she realizes that they have made a mistake. Denial is one of the most common reactions. Unfortunately, denial only serves to increase your personal stress load and often strips you of your credibility. Other consequences occur, such as embarrassment, emotional stress, decreased self-confidence, increased suffering or injury to the patient and social alienation. Imposed consequences may come in the form of discipline, civil liability and legal problems. Initial reactions, such as panicking and pointing your finger at others in blame, tend to backfire. When you point one finger at someone else, three other fingers point back at you.

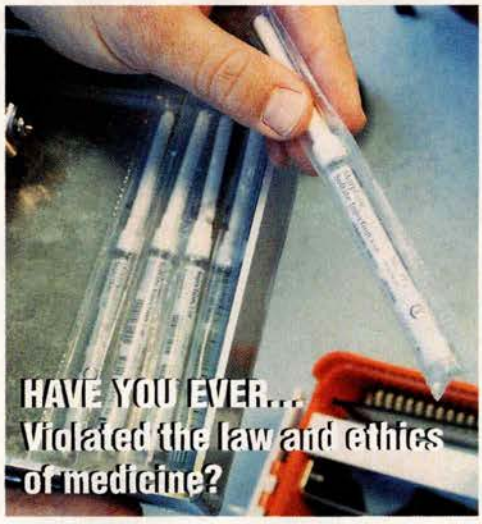
EMS mistakes are inevitable but educational. This unofficial rating scale illustrates that not all mistakes are equal:

LEVEL 1: *You can ignore these mistakes without immediate consequence.* For example, let's say you accidentally drive through a red light while talking with your partner about your last cool call. No one



EMS mistakes are inevitable, but educational.

saw you do it, and you didn't hit anything. You were lucky to get away with it, and you silently breathe a sigh of relief. Even though no damage occurred, it's important to acknowledge this as a mistake and learn from it.



LEVEL 2: *Mistakes at this level should make you reassess your methods.* You're running a critical gunshot call and—despite multiple attempts—you can't get an IV line. Your partner bails you out and establishes one. You failed in your objective, causing a delay in the patient's receipt of IV fluids. Because your partner completes the objective, the patient survives.

LEVEL 3: *These tricky dogs produce serious career-related consequences.* Your lawyer can't get you out of your last speeding ticket and you will lose your driver's license. No license, no job.

LEVEL 4: *Mistakes at this level have negative consequences on your patient's health or comfort.* You hand the IV bags, including the one with the lidocaine drip, to a police officer while you call the hospital. After hearing you discuss a fluid challenge on the phone, the police officer cranks the lidocaine drip wide open. Eight hundred milligrams are administered before you realize what happened, and the patient dies.

LEVEL 5: *These mistakes impact your career and your life.* Scenario 1: You lose your temper and deck an alcoholic patient who has become verbally abusive to your partner. Scenario 2: A DEA officer wants to know why all the morphine pre-fills on your rig have saline in them, creating a placebo that will be ineffective in treating future patients. In both of the aforementioned scenarios, you violate the law and the ethics of medicine.

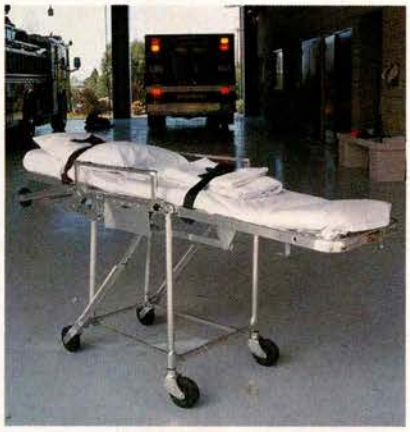
Clearing Your Conscience: 5 steps to manage mistakes

Are you a whiz at handling mistakes? If not, here are some suggestions that you might find helpful:

1. **Admit mistakes** (but don't advertise them). Corporate risk managers despise this recommendation. However, telling the truth rarely hurts in the long run. Tell the physician in the emergency department and your boss that you gave bicarb instead of D50, but don't rush to tell the patient or their family.
2. **Do something.** Take active steps to ensure that you will not repeat the mistake again. Attend an emergency driving class. Promise yourself to always triple check medications for correct drug, correct dose and expiration date and the correct route before administering them.
3. **Do something *now*.** Don't hesitate to correct mistakes when you make them. Doing so will minimize damage. If you were rude to a charge nurse, go back and apologize. If you caused an auto accident, help the injured or at least direct traffic.
4. **React gracefully to natural and imposed consequences.** Whatever you do, don't blame others for your mistake, complain about it or try to explain your way out of it. As author Stephen Covey says, "You cannot explain your way out of a situation that you behaved yourself into."
5. **Share mistakes with others.** Experience is sometimes the best teacher. You don't need to plaster your face into a windshield to learn to wear a seat belt, right?

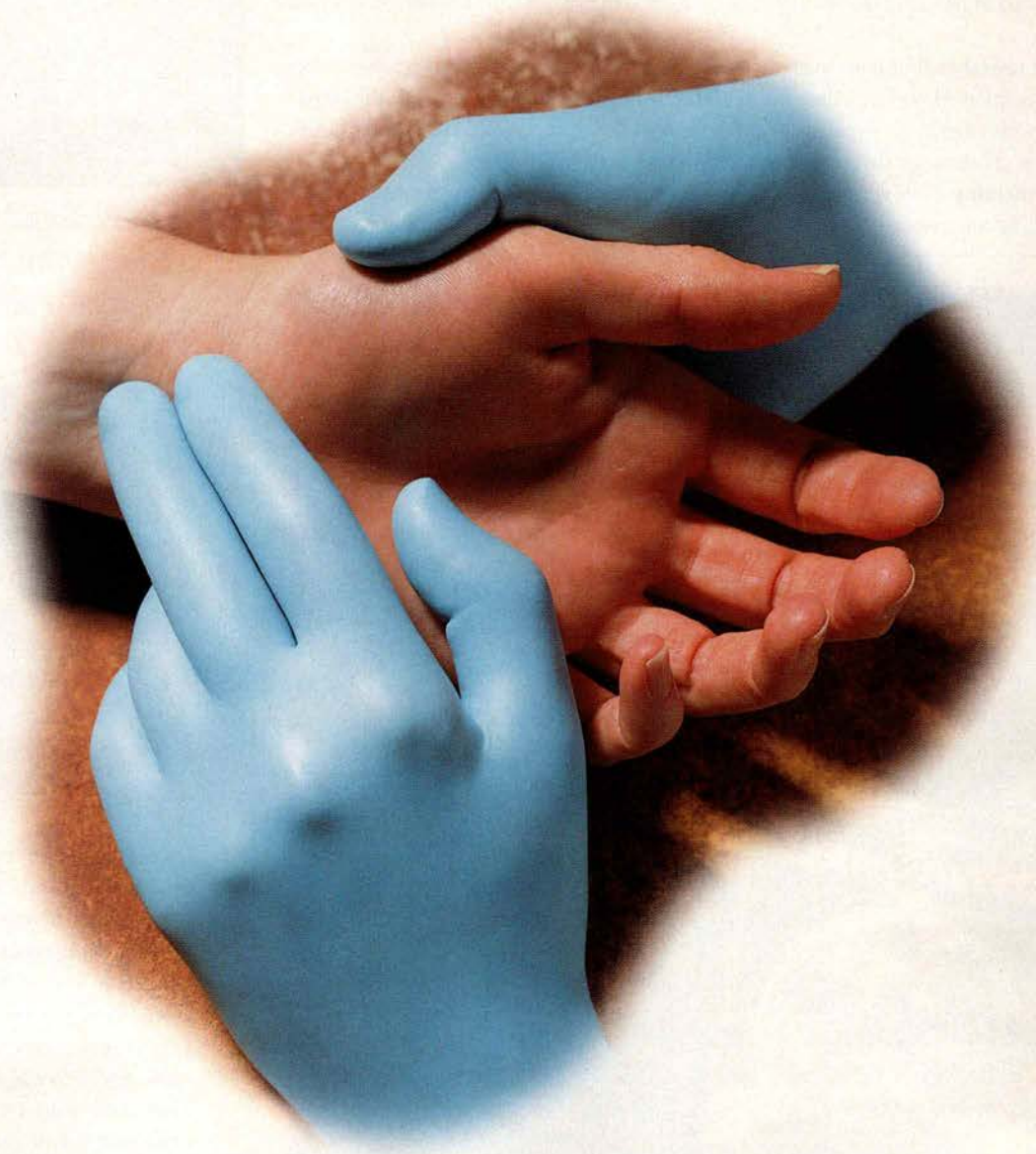
Paul Murphy, BS, NREMT-P, is a paramedic and instructor with the Rocky Mountain Training Institute. Mike Taigman is an independent educator, facilitator and consultant. He is also a frequent JEMS *contributor.*

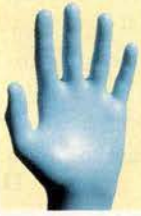
HAVE YOU EVER...
Cleaned up the rig and left for a call without your stretcher?



There's a fine line between life and death.

(Thousandths of an inch to be exact.)





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POWER

10 techniques to help you become a better classroom performer

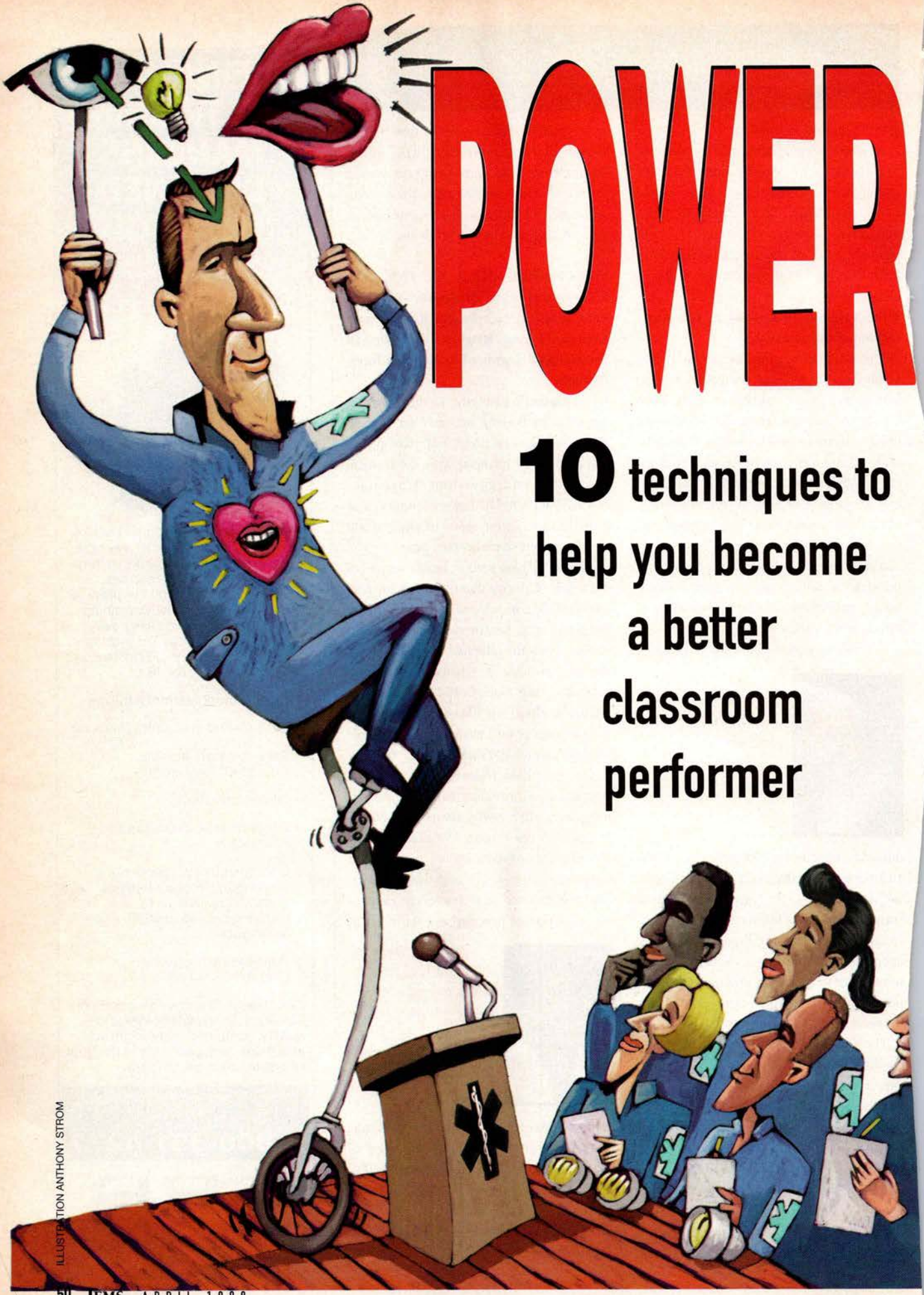

ILLUSTRATION ANTHONY STROM

Stepchild of Medicine

sion and ultimately consume us.

I cannot overemphasize the importance of being active participants rather than passive observers. A unified profession will give us the foundation for a national presence and voice. In today's classroom we must plant the seeds of this future harvest. EMS instructors hold those seeds in their hands.

Mike Taigman, independent educator, facilitator and consultant

People graduating from today's EMT programs have the skills to handle car wrecks, help deliver babies and perform CPR. They also have the expectation that life will be filled with opportunities to use their new skills. They eagerly anticipate William Shatner profiling them on prime time TV. Those that join volunteer EMS organizations may have their dreams come true. Those who decide that they will make EMS their primary occupation often spend their days transferring dialysis patients from nursing homes rather than extricating babies from upside-down Volvos.

Customer-supplier alignment is the most

The current product does not meet the specifications of the customer.
—Taigman

important issue facing EMS educators. EMT and paramedic education programs take bright young people (raw material) and train them into EMTs and paramedics (products) hired by fire departments, EMS agencies and ambulances services (customers). EMS education programs are suppliers and EMS provider organizations and the patients they serve are customers.

The current product does not meet the customer's specifications. The skills and expectations of new EMTs are out of alignment with the actual work of most EMTs in paid positions. This causes problems for provider organizations and their customers. It also causes dissatisfaction for EMTs.

Paramedic programs would improve greatly by embracing the new paramedic curriculum. I also think it's time for us to have two kinds of EMT programs. The current type for volunteers and a new one for people who will make their living in this profession. This new program would include the skills necessary to provide compassionate, customer-service-oriented health care in addition to basic EMT skills.

Will Chapleau, EMT-P, RN, TNS, CEN, EMS coordinator, St. James Hospital, EMT program coordinator Prairie State College, Chicago Heights, Ill.; chairman Pre-Hospital Trauma Life Support International

Our constantly changing health care systems put increasing pressure on EMS to evolve along with them. EMS has always responded and changed with the medical profession and government agencies involved in EMS. The new millennium may bring changes in the scope of practice and the philosophy of prehospital practice.

Most of us have seen or heard samples of the winds of change that feature prehospital care providers in roles as varied as primary caregiver and health care system gatekeeper. With the potential for changes like this on the horizon, science and research must find their place in EMS. The greatest challenge ahead for EMS instructors is to plug ourselves into evaluating the people we train and the EMS systems they work in.

Our first EMS lessons stress that prehospital care providers comprise patient advocates; after safety, the patient comes first and all else second. We need to study the effect of our work on our patients and determine what works and what doesn't. The studies need to review every element of our scope of practice and we need to

The greatest challenge ahead for EMS instructors is to plug ourselves into evaluating the people we train and the EMS systems they work in.
—Chapleau

replicate them in the inner city, the suburbs and wide-open spaces. We need to take advantage of the vast variety of EMS systems all over the world, hold ourselves up to the looking glass and find out if what we are doing works. If it doesn't, we must find out what does.

lence far above the average performer. You can raise the level of your performance by practicing my top 10 strategies for ways to improve your presentation style.

Strategy 1: Know Your Subject

Daniel Webster said he would just as soon think of appearing before an audience half-naked as half-prepared. Through study and experience, you earn the right to speak to your audience. In effect, a teacher says to his or her students: "Trust me." You must achieve expertise in your subject by going beyond the certification level of the course you are teaching and acquiring more knowledge than you will ever use. Many adult students will not enter your class with extensive science backgrounds. So, you must be able to explain complex medical and physiological concepts in simple terms. Great teachers have the ability to make what they know accessible to their students. For example, you can demonstrate for students the similarity of congestive heart failure to a milk bottle with three inches of fluid in the bottom. When you show them how the fluid gets distributed across the entire bottle when you lay it on its side, they should easily understand why we don't lay CHF patients flat on a stretcher, flooding upper and lower lung fields. Knowledge is the key to making landmark improvements in your teaching.

Strategy 2: Be Sincere

Comic actor Bill Murray once said,: "The key to acting is sincerity. Once you learn to fake that, everything else is easy." It's not enough to know your subject—you must believe in it. Many people become famous because they believed wholeheartedly in the cause they were supporting. Before Billy Graham became a world-renowned preacher, he was the top Fuller Brush salesperson in the Carolinas. When asked for the secret to his success, he answered, "I believed in the product, and sincerity is the biggest part of selling anything."

According to historians, Abraham Lincoln was a public speaker without grace or polish. On Nov. 19, 1863, he was called upon to dedicate a national cemetery at the site of the Civil War battlefield at Gettysburgh, where more than 7,000 Confederate and Union soldiers had died a few months earlier. In an attempt to reconcile and heal the nation, he spoke with a fierce commitment. His brief remarks contained an eloquent and concise definition of democracy. It took less than two minutes to deliver one of the most important speeches in American history.

Eye contact is a simple, yet powerful way to communicate. When you teach, don't fix your gaze on a spot on the wall at the rear of class. Don't bury your nose in your notes or teaching outline to avoid making eye contact with your students. Don't move your eyes from your notes to the board or to a slide on the screen, looking everywhere except at your class. If you're doing these things, you are addressing objects, not students. But be careful not to prolong the eye contact until it turns into a psychotic stare. You'll know it's too long if the students look away or start to

Gregg Margolis, an EMS educator at the Center for Emergency Medicine in Pittsburgh, captivates his audience with his teaching style.

Table I. Top 10 Ways to Become a Better Teacher

10. Know your subject.
9. Believe in its importance.
8. Be eager to teach it.
7. Control your voice.
6. Vary your pace.
5. Fit Match your actions to your words.
4. Position yourself around strategically.
3. Use the pause frame
2. Make an emotional impact
1. Put your heart into it.

of the PULPIT

BY RICHARD A. CHERRY
M.ED., NREMT-P

THROUGHOUT HISTORY MANY GREAT LEADERS have been great orators. The ability to lead people toward a common goal requires a powerful speaking style. It's also imperative that teachers be effective, persuasive public speakers.

Of all the lectures and presentations by teachers you have seen in your lifetime—including classroom experiences from high school through college, seminars, conferences and training programs—how many of them were truly outstanding? How many of them do you even remember? Most people can count them on one hand. Isn't it amazing how few come to mind? It's unfortunate that, of the many teachers we've had, only a few were memorable.

When we think back to our school days, we usually find our favorite teachers were those who made their subjects come alive. They loved what they were teaching and infected the entire class with their enthusiasm for the subject.

Teachers with exceptional knowledge and a dry delivery put us to sleep before we learn anything. And those lively entertainers who have no relevant information to offer usually waste everyone's time. The rare few combine expert knowledge and experience with a dynamic presentation style—and you never forget them.

I have learned two important lessons in more than 20 years of teaching: 1) improve your ability as a public speaker, and you improve your effectiveness as a teacher; 2) it's not as difficult as you might think to sharpen your presentation skills.

In the age of video, MTV and ever-shrinking attention spans, teachers must not only inform but entertain and inspire. Just as stage performers concentrate on perfecting their skills, there are many things you can do to improve your classroom presentation techniques. After mastering the mechanics of their roles, all great entertainers add personal touches, raising their level of excel-

wilt in their chairs.

Adults are expedient, practical learners. They learn what is relevant and important to them. Sell them on the relevance of what you're teaching and allow them to attach a value to it. If you explain cyanosis to your students as a vital sign that often comes too late to be of benefit to the patient, they will understand the more important value of a pulse rate. Since they will often adopt your value system, you must believe in the importance of what you teach. If you don't, *why* are you teaching it?

Strategy 3: Teach with Enthusiasm

According to David Peoples, an expert on giving effective presentations: "People are persuaded more by the depth of your conviction than the height of your logic, more by your enthusiasm than any proof you can offer." You must be eager to teach. If you're not, rethink your commitment to EMS education. During my student teaching days in college, my supervising instructor once told me, "If you aren't fired up with enthusiasm, you will be fired with enthusiasm." When you are enthusiastic, you are showing a genuine affection for your students and your subject.

Strategy 4: Control Your Voice

How you say something has as much impact as *what* you say. Just because you speak doesn't mean your students are listening. Getting them to listen is the key. This requires a speaking style that attracts and maintains their attention. Experienced speakers vary their voice to express the intent of their words and add dramatic effect. Inflection and tone give your voice personality. They allow you to shade and even change the meaning of your words. All great speakers vary the tone of their voices to give real meaning to their words. Use this technique to give your students subtle clues to your feelings about the things you teach. Referring back to example of cyanosis, you can raise your voice and tell the students: "If you fool around waiting for the patient to show signs of cyanosis before you start to administer oxygen, you might as well call for the coroner because your patient will soon be dead."

Do you sound like a priest reciting his daily prayers or a hot dog vendor at Yankee Stadium? Speaking too softly is as ineffective as shouting your words. For just the

right volume, pick someone in the last row of the classroom and adjust your volume so they can hear you easily. Use this setting as your baseline. Then raise your voice as you become excited and lower it as you calm down. Dropping your voice to a near whisper, gets everyone's attention. Use this technique when you want to emphasize the most important points of your lesson. You also can exaggerate your voice to draw great emotion to what you say. Be a ham. Let your emotions show when you teach. Expose your true feelings.

Strategy 5: Vary Your Pace

Pacing your presentation is like driving a car. You start slowly and gradually accelerate until you reach your cruising speed. You speed up or slow down depending on changes in road condition, traffic or terrain. At a red light you stop completely. Try the same style with your next presentation. Let the importance of the material dictate the speed of your teaching. By varying your pace, you take your students on an interesting and exciting educational ride. They'll learn that when you slow down, important material is being covered and when you're moving rapidly, it is relevant but not critical content. To help keep your students attentive, vary the rhythm of your delivery and avoid the "metronome effect." A hypnotist uses a constant volume and speed to put a subject under hypnosis or produce sleep. Hypnotized or sleeping students are not effective learners (Table 2).

Table 2. Are Your Students Interested?

BEHAVIOR	INTERPRETATION
Alert and expressive	Students are interested. Keep up the good work.
Quizzical frown	They think you're crazy or you're confusing them. Go slower and explain things more clearly.
Looking around room	You're boring them. Change gears.
Looking at their watches	Mutiny is close. (See Strategy 3).
Eyes half-closed	They've tuned you out. Take a break.
Eyes closed	Give up teaching. Consider a career as a hypnotist.

Strategy 6: Fit Your Actions to Your Words

Nonverbal language speaks louder than words. We are capable of hundreds of distinct gestures of the face, hands and body. Yet in spite of this tremendous variety of available gestures, some teachers stand before their classes and use only their vocal cords. While your words say one thing, your facial expressions and body language can say something entirely different. Use your body to heighten the effects of your words. How can you spread enthusiasm if you stand lifelessly in front of the room? While I don't recommend jumping around as though you just won a million dollar lottery, be energetic. Vary your style by using planned, deliberate, controlled movements at appropriate times. Take command of your stage. Words and information are simply not enough. Often, it's not what you say that counts, but what your students see and hear. Put a high concentration mask on your face as you explain how difficult it can be to communicate with a patient with a mask in place. Show them how easy it is to hear a patient if you move the mask away from their face as they speak.

Strategy 7: Position Yourself Move Around Strategically

When you teach, do you stand in front of the room like a statue or pace across the floor like a caged lion? Do you rock back and forth like a boat on rough water? Movement is important, but it should be calculated.

I use three distinct areas in my classroom strategically when I teach. The first area is my *home base*. My teaching originates from this area. It may be next to the overhead projector, or at the center of the room or at a table where my notes are located.

The second area is a place I wander to that changes my perspective of my students and theirs of me. I call this the *warm zone*. I use this area to expand on my thoughts, to explain ideas, to ask questions—anything that allows me to leave my teaching outline momentarily and improvise. It's where my students can expect something a little different.

Finally, I select an area—a nonphysical one—just beyond the psychological borderline that separates me from my students. Crossing that imaginary line is a direct attention-getter. I use this area for those few times when I want to emphasize important points of the lecture. I call this the *Hot Zone*. I use this with the pause frame technique (Strategy 8) when I want to make a lasting impression. I do this no more than once per hour of lecture time.

Strategy 8: Use The Pause Frame

The use of a pause in your lecture or presentation is an effective way to frame important points. It is a very powerful attention-getter. Learn to use them appropriately. The trick is to pause before and after the important point. This frames it. By pausing before the point, you grab everyone's attention. You are announcing, "Listen, this is important." By pausing after the important point, you allow them to reflect. Use the pause frame for take-home points from your class. For example, you can say, "Do you realize that a person with a fractured femur can lose up to one liter of blood in the fracture area?" Pause. "One liter is almost 20 percent of an adult's total blood volume." Pause. After your students become familiar with your style, they will easily recognize that what you are about to say is important.

If you want a quick lesson in voice communication, listen to radio personality Paul Harvey. Wherever you live in the United States, you can hear his reports three times daily. Besides having a unique speaking voice, he fills his news stories with peaks, valleys and dramatic pauses. He speeds up, he slows down, he pauses. An effective speaker can emphasize key points in this manner.

Strategy 9: Make an Emotional Impact

When your aim is to convince, it is more productive to stir emotions than to arouse thought. Winston Churchill knew this, as did John F. Kennedy. Every effective public speaker knows this. Make every presentation the most informative, entertaining and inspirational classroom experience your students have ever had. Help

Complaint-based Education

Learning to look at the big picture

BY DEBRA CASON

THESE DAYS, WHEN EDUCATORS SIT AROUND THE campfire talking about EMS curricula, the buzzword "complaint-based" probably hovers in the air. A growing number of these educators swear by complaint-based education. This approach to teaching clinical information begins with the presentation of a patient's chief complaint. It proceeds deductively through assessment to gather enough information to make the best treatment and management decisions.

Traditionally, the instructor presents clinical information using a systemic approach, such as cardiac or respiratory diseases, then moves to conditions in that category and how to assess and manage them. For example, the teacher presents one or more classes on cardiac diseases, discussing angina, acute myocardial infarction and other cardiac-related problems. During the class, the instructor discusses the pathophysiology of angina and AMI, how the conditions present, what the accompanying signs and symptoms of myocardial infarction are and how to assess and manage the MI patient.

In the complaint-based model, the instructor presents the student with the chief complaint of chest pain. The discussion centers on pathophysiology of chest pain and the most life-threatening conditions that can cause chest pain (AMI and coronary artery disease). Because not all chest pain indicates an MI, the class discusses other causes of chest pain. The student makes an assessment specific to a patient with chest pain, considering clues symptomatic of certain conditions, while eliminating others. Through this process of elimination, proceeding from the broad category to the specific problem, the student determines the appropriate management.

Chest pain, however, is not the most telling example. Let's focus on a ruptured ectopic pregnancy, a life threatening condition that EMS providers see in the field. The traditional model introduces this topic during discussion on gynecological emergencies. After hearing about the pathophysiology, students learn that this patient has low abdominal pain, experiences dizziness and fainting and may be in shock.

In the complaint-based model, students are presented with the chief complaint of dizziness or fainting and learn to assess for life threats, such as shock or impending shock. If the student identifies the condition accurately, they can immediately initiate management and continue to assess for the most likely causes of fainting and shock. For the complaint of fainting alone, the student assesses the patient for possible underlying cardiac, neurological, vascular or gynecological causes, which all stem from this common chief complaint. As students continue investigating the cause of the pain, they would find a complaint of lower abdominal pain consistent with a ruptured ectopic pregnancy.

Some EMS educators believe strongly that complaint-based education represents a superior method of teaching clinical content. Advocates say graduates of a complaint-based curriculum are more likely to visualize the big picture, quickly divide the assessment information into likely possibilities, then treat the patient more quickly and effectively. Students of this approach consider a broader spectrum of possibilities than traditional students and narrow the list of causes through assessment.

Students taught by traditional methods take the chief complaint and have a comparatively shorter list of options; consequently, they may have tunnel vision, looking past possible causes. Approached from complaint-based education perspective, the chief complaints of chest pain, abdominal pain, extremity pain, dyspnea, dizziness, fainting and altered level of consciousness may all suggest MI, but the student learns other indications that will rule out this condition.

Most experienced instructors employ methods within traditional curricula to enhance the critical thinking skills of their students. A key to success in any EMS educational program lies in providing students with ample opportunity to solve problems and make assessments as close to real life as possible.

Do students that attend the complaint-based course end up more prepared to think, act and manage the patient than their counterparts in a traditional program? We don't yet have a conclusive answer, but some educators are asking the question.

Debra Cason is an associate professor program director for emergency medicine education at the University of Texas Southwestern Medical Center, Dallas, and author of the recently released textbook, Paramedic Field Care: A Complaint-Based Approach, *published by Mosby-Year Book Inc.*

them attach value to the material. Tell stories of real people who suffered the various illnesses and injuries you teach and let your students know the importance of your subject. Tell them, "If you are lazy and lay my grandmother flat when she's in CHF instead of sitting her upright in a chair, you'll drown her in her own fluid." You'll see the point register in their eyes. Make an emotional impact and your students may remember the moral of the story much better than cold facts and figures about some disease entity.

Strategy 10: Put Your Heart Into It

This is the most important ingredient. Years ago, I attended a summer concert in the Carrier Dome at Syracuse University. Linda Ronstadt, a particular favorite of mine, was on the bill, and I anticipated an outstanding performance. Unfortunately, what I got was an hour of disappointment. She and her band performed a collection of my favorite Linda Ronstadt songs from the 70s and 80s. She sang flawlessly and the band's timing was impeccable. But the show was awful. There was absolutely no passion. It was obvious that they were bored and disinterested in their music. It showed. You cannot fool your audience. Sincerity and enthusiasm are difficult to manufacture.

Years later, I was dragged, literally, to a concert given by the Everly Brothers. I was not a big fan when their music was new, but I agreed to go. Much to my surprise, I found two guys who still loved the music they created and recorded more than 25 years earlier. Their performance was memorable. I still consider it among the best concerts I have ever seen. The difference was their passion for their music. When you put your heart and soul into something, it becomes special to you and your audience. You cannot fake your passion.

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Three years after the Murrah bombing, rescuers cope with the changes in their lives

Oklahoma City Rebuilds

BY MARC-DAVID MUNK, AEMT-CC, NREMT-I

In 1987, paramedic Robert O'Donnell helped rescue tiny Jessica McClure from a well shaft in Midland, Texas. He became a local hero, displayed on the front cover of hometown newspapers around the world. Overnight McClure's rescue became O'Donnell's ticket to television interviews, an acting part in a movie-of-the-week and glossy stories in People.

Then, the media left Midland. Months passed. The miraculous rescue of Jessica McClure–the culmination of years of training and preparation–became just a historical anecdote. O'Donnell went back to his shifts at the firehouse, to house payments and car tuneups. As the years passed and the long-standing stress created by McClure's complicated rescue went untreated, O'Donnell grew withdrawn and depressed. He divorced, and then left the fire department amid allegations of prescription drug abuse in 1992. Nearly eight years after the McClure rescue (and just eight days after terrorists destroyed the Federal Building in Oklahoma City), O'Donnell snapped. Parked in a field near his parent's ranch in Stanton, Texas, he wrote a suicide note, loaded his shotgun and shot himself to death in the cab of his pickup.

ON APRIL 19, 1995, A TRUCK BOMB DEMOLISHED OKLAHOMA City's Alfred P. Murrah Federal Building. One hundred sixty-nine people died in the explosion. An entire city block was destroyed. The blast injured scores of people and damaged buildings miles away.

Within minutes, the city was transformed by rising smoke and dust. Images of the blast riveted worldwide CNN audiences and covered the front page of every newspaper in the country.

At the Oklahoma City Fire Department and at EMSA—the Emergency Medical Services Authority that serves Oklahoma City—the explosion generated a response unlike any the city had ever seen. The world's gaze focused on emergency amputations, falling rubble and sweating police officers, firefighters and EMSA personnel carrying dying babies from the debris.

Overnight, overwhelming attention focused on Oklahoma's

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Mourning place (this page)—the fence surrounding the Murrah Building site has become a symbolic memorial for the citizens of Oklahoma City. Decimation (left)—an aerial perspective of the Murrah Federal Building remains after the explosion.

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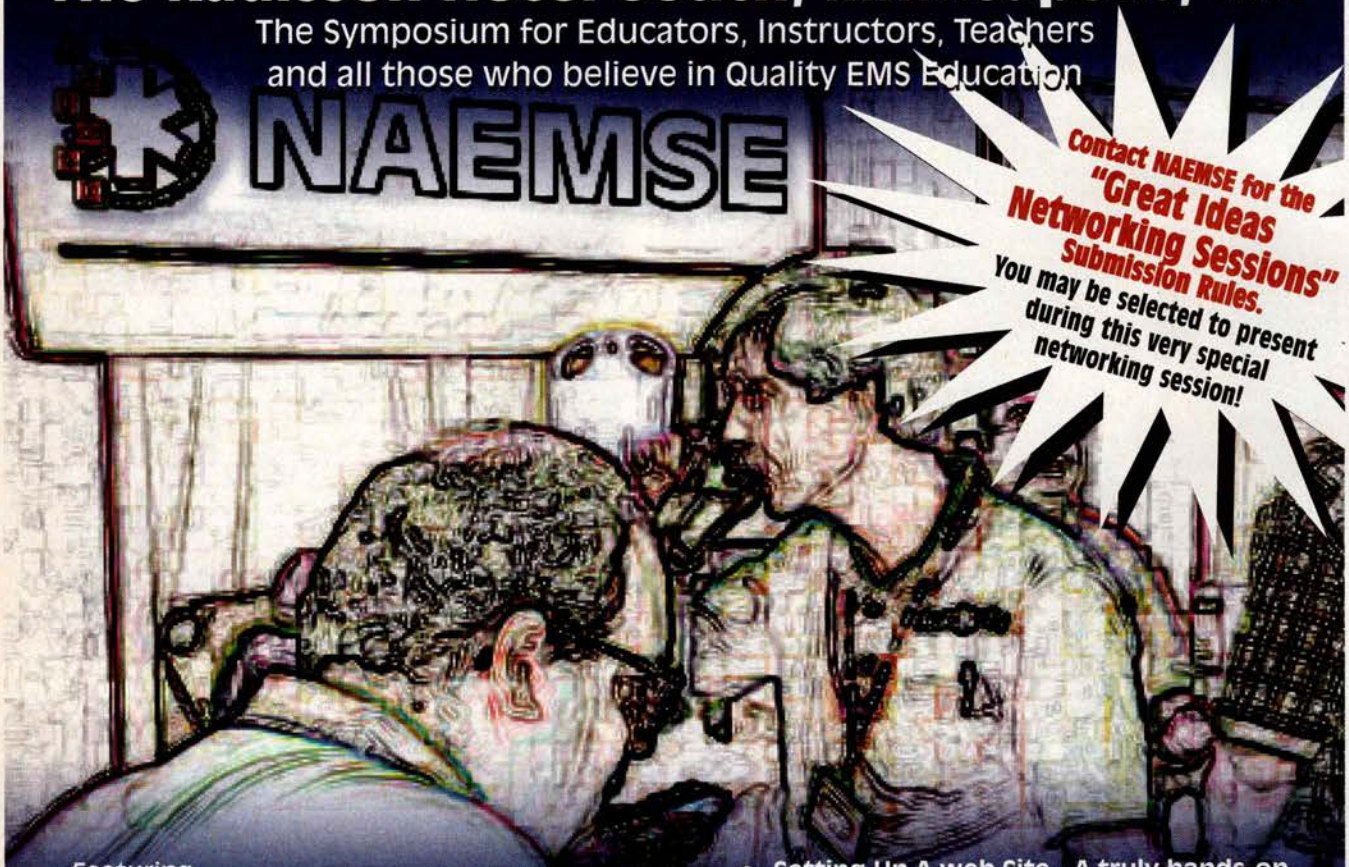

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emergency workers; they became America's emergency responders. And firefighters, EMTs and paramedics in all parts of the country have benefited from the rescue efforts in Oklahoma City. For weeks after the blast, citizens visited firehouses and stopped ambulances to say thanks and great job.

For EMS in particular, the Oklahoma rescue was an opportunity to shine. Americans finally saw exactly what occurs during a call—what medical care in the streets is all about. By watching evening newscasts and reading special reports, they learned about triage and transport during the "Golden Hour." It was a pivotal moment in the industry's evolution.

The Madness Ends

Then the world lost touch with the rescuers in Oklahoma City as other news diverted our attention. Yet when the rubble was cleared and the last lives were saved, EMSA and the fire department remained to deal with the experience. In the months and years that followed, everyone involved learned about criminal justice, media relations, political maneuvering and stress management. Today, three years after the blast, much has changed in Oklahoma City.

Flashbacks to Ground Zero

Perhaps the sheer magnitude of the blast remains the most significant image embedded in responders' minds. The Murrah building has since been razed; its presence replaced by a fenced lawn. Visitors and rescuers alike remark on the enormousness of the lot where the building once stood. In Oklahoma City's grid of streets, the Murrah building took up an entire block. Affected buildings near the blast still have no windows; some are gutted.

Rescuers remember feeling the blast. On the morning of April 19, EMSA Communications Supervisor Paul Holman was working in the EMSA offices several miles from the Murrah building. "I was in my office and suddenly the building shook. Ceiling tiles fell all over the place. I looked out the window and saw a woman lying on the sidewalk across the street. The blast blew her down, and she was getting up—looking toward downtown."

Mark Robison, EMSA director of operations, said: "I thought someone had blown up our garage. I could feel the blast while standing inside. I ran to the back of the building to look. It wasn't the garage. I knew anything that loud had to have hurt someone." As Robison left the building, he saw a huge column of smoke rising over the downtown area.

The smoke and concussion led Mike Murphy, EMSA field supervisor, to conclude that a major incident had occurred. "I figured it had to be a natural gas explosion or an airplane accident," he said. "I hopped in a command vehicle to respond. I don't remember the actual route I took to get to the scene. I was making 16,000 calculations: how to set up, what to set up.

"It was obvious the bombing would pose an enormous challenge for the rescuers. "A lot of our patients were at death's door," said Murphy. "Our involvement was intense for two-to-three hours, and it was pandemonium. Because of the bomb scares [after the initial incident], we had to keep moving units and staging areas around."

In the first hour following the incident, EMSA transported 210 people—more than some services in the United States transport in a year. All but one of EMSA's ambulances were deployed to the incident. This included a truck that had been in the shop for a transmission overhaul; mechanics hastily grabbed the transmission from the corner of the shop and bolted it back into the ambulance in time for two arriving medics to drive it to the scene.

In the communications center, all hell broke loose. Calls flowed into the center immediately after the blast and didn't slow for hours. "Calls came from all over–farther and farther away—six to seven blocks from the smoke," recalled Holman. "I looked at the TV that was on in our center. It showed a picture of the Murrah building. No one could say a word. We just screamed at the screen. 'It's gone!' "

On scene, triage centers were established and a steady shuttle of ambulances—36 in all—transported patients to hospitals, often two at a time. Rescue personnel said interagency cooperation was excellent: Fire concentrated on rescue; EMS on patient care; and police ensured excellent access for all apparatus. That morning, emergency response requests outside of the bombing area virtually ceased. "We had folks call with chest pain later that day and say they were watching TV and didn't want to call," he said. "We had seven calls between nine and noon, and all were apologetic. Normally we get 15 to 20 calls in an hour."

Emotional Rescues

According to Oklahoma City Fire Lieutenant Rick Wilson, intensity made the scene dreamlike. "You got tunnel-vision even though you didn't want it," he recalls. "You were so focused on the task at hand."

Emotions on scene ran high. Bomb threats that came in after the initial blast

In the first hour following the incident, EMSA transported 210 people—more than some U.S. services transport in an entire year.

June 1995: The *JEMS* special issue included coverage of scenes, such as this one, of rescuers attending to Murrah victims.

only increased the stress levels. Holman, who had left the EMSA offices to coordinate on-scene communications, reminisced. "The words rang in my ear, 'Evacuate the area immediately; they have found another bomb.' I saw a firefighter running out of the area. We made eye contact, and I saw he was scared—really scared. I know him, and he's a tough guy—he runs into burning buildings for a living. I thought, 'Hey, if he is this scared, it's time to go.' "

When EMSA and the fire department were told the rated occupancy of the building was 900 people, and they should prepare to treat that number, the intensity turned up 20 notches. Reports suggested that after the initial wave of 200 wounded, another wave of injured would be found in pockets between collapsed floors. But the second wave never happened. Instead, there was a trickle of viable patients extricated from the building.

"There weren't the two- to three-hundred people in the second wave," recalled Murphy. "There was so much anticipation [but] it never materialized. We knew we hadn't seen 900 patients. But we kept being told that there could be pockets of patients and we waited and waited. I had planned on using outlying hospitals for the second wave–it was all set up. But it was a big letdown from a logistical standpoint."

Paramedic William Lindsay remembers, "After the initial rush—the adrenaline, the critical patients—we sat in the truck from 11 a.m. to 2 p.m. They weren't finding anyone alive, so they sent crews into the city. It was back to normal system status again [for EMS] that night."

Coming Down

By day's end, medics and firefighters were in various stages of shock. "I got home about 8 p.m. that night" recalled Holman, who had worked in the field for much of the day. "I didn't say anything. I just wanted to wash my face. I was mad. I wanted some water. My wife walked toward me, and I started crying, 'This doesn't happen here.' We didn't say anything for 10 to 15 minutes. The kids were watching TV and that's all there was to see—the bombing.

"My daughter looked up. She said, 'Why Oklahoma City?' I looked back and said 'Why not Oklahoma City?' " remembered Holman.

By 10 p.m. that evening, everyone knew that the number of victims left alive was lower than anyone had hoped. "The CISD [critical incident stress debriefing] started an hour into it," said Murphy. "I was worried about it from the get-go. I knew this was a major event with potentially serious complications. The bomb threat made everyone take a break and stand back. There was a denouement, a gradual release of steam. As each hour ticked by, we knew there were no more survivors. There wasn't a real hard [emotional] crash. The realization set in over a period of time."

> "We had folks call with chest pain later that day and say they were watching TV and didn't want to call," says Holman. "We had seven calls between nine and noon, and all were apologetic. Normally we get 15 to 20 calls in an hour."

At EMSA, managers immediately called in additional CISD counselors, including some from AMR's Connecticut operations. The fire department supplemented its in-house CISD team with outside professionals to deal with the volume of counseling required. Management at both EMSA and the fire department made attendance mandatory. "We forced everyone to be exposed to CISD. That met with some resistance," says Murphy. "There was a wide variety in the reactions we encountered: For some, there was total absorption with what was going on—total ownership. Others left the scene and were back on an ambulance four hours later. Others got off the truck, left and didn't look back. And then we saw everything in between, all are examples of stress."

The nature of the bombing required different stress debriefings for the fire department and for EMSA. Primarily, EMS response was limited to the first few hours of the incident, while the fire department's rescue and recovery continued for weeks. Medics were thrown into the incident, totally immersed for hours. When their jobs ended, they were expected to return to normalcy. That rarely happens after a call like this.

Surprisingly close to the blast,the Survivors' Tree survived serves as an unofficial monument to the victims.

Paramedic William Lindsay and Field Operations Supervisor Ashley Cudd were among those who served on April 19, 1995.

The firefighter response was longer, requiring a gradual withdrawal from the incident. "After the fourth day it changed from a rescue to a recovery," recalled fire department Major Glenn Clark. "There was a delayed stress reaction. Body recovery was tough: the crews would find two bodies and then we would pull them out." The process seemed to continue forever.

Holman attended the stress debriefings: "I wasn't going to go, but I did. I'm glad. Did it change my outlook? Probably not. I didn't want to talk to anybody. Were people candid? As a group, medics are generally not candid; they tend to hold it in. It took our group [in communications] about a year to let go of it. They wouldn't let go. Every conversation eventually steered back to the bombing."

"You know firefighters," says Clark. "A lot of people tried to hide their feelings and deal with things their own way." (L-R): Lt. Ray Stuart, Major Glenn Clark, Firefighter Jonathan Akright, Lt. Greg Heard.

At the fire department, feelings were mixed. "They debriefed us after every shift," recalls Clark. "You came out of the site and went to debriefing. But, you know firefighters. A lot of people tried to hide their feelings and deal with things their own way. Some didn't want to talk about it. [CISD] was good for a lot of them." But stuffing feelings inside doesn't help much, says Wilson. "They kept trying to put closure to the thing, but closure never happened. It's not over. For the people who were really there, it's not over."

At both the Fire Department and EMSA, the stress debriefings continued for more than a year. EMSA management arranged for debriefings at one-week, one-month and six-month intervals. "It was beneficial at the one week interval," recalled Robison. "After the first week, everyone noticed they were suffering symptoms of stress. So the one-week period was critical. After the six-month period, it wasn't mandatory. The one-year anniversary was special to all of us. But that was enough. By then, the medics were really tired of it."

Aftershocks

Perhaps the biggest argument in support of aggressive CISD is that neither the fire department nor EMSA have reported any employees who have left work or the rescue industry as a result of the bombing. In fact, some firefighters were inspired to pursue specialist rescue training after the incident. "To me, stress debriefing is the key to why we have done as well as we have," claims Robison.

Still, stress reactions emerge when and where least expected. "In this business, there are all sorts of stressors," said Murphy. "So when I have a medic with a behavior problem or a crisis at home, it's hard to tell whether it's related to the bombing, to the stress of the following 12 months or [to another] personally significant call."

When examining the causes of stress after a major incident, authorities have learned to look beyond the obvious. Often, stress did not result directly from the trauma of dealing with victims–but the emotional aftereffects. "[The rescue] was just a job," says Wilson. "Around here, people live and die all the time. But we've become personal with people who lost family in the blast. One little girl's mom set up a restaurant near the scene. She opened it in her daughter's name, and we pass by it every day. You normally don't know that much."

For many EMSA street medics, unrelenting media attention induced stress. Initially, many medics felt the media ignored their contributions–feeling that despite their superb response to the incident, nobody knew or cared about their efforts. This may have appeared to be the case because the media focused heavily on the fire department and responding police services. "That was the worst part. I was personally insulted by the press coverage," says Lindsay. "We transported 205 people during the early phase while the fire department was moving concrete. The media and the public didn't and still don't know who we are or what we do. "

Murphy acknowledges that having their efforts largely ignored by the media was "a big stress on the medics. We didn't have a spokesman and the fire department did. We were in and out of the scene, and nobody spoke for us. The media knew they could go to the fire department for information, but there was no one to [speak for] us, which meant that fire department involvement was accentuated."

Clearly, the bombing taught EMSA a critical lesson: Appropriate media relations comprise a vital part of any operation. "Within 15 minutes of the blast, the media was calling," says Holman. "CNN called every public safety office and finally got through to us. I took two calls from CNN in 30 minutes. One caller asked, 'What hospital are injured being taken to?' I said, 'All of them' and hung up."

Meanwhile, the fire department launched an all-out media relations campaign. "We had four or five people assigned to do nothing but give the media information and deal with stories," said Fire Chief Gary Marrs. "We put a lot of effort into learning their deadlines, when they had to do news breaks. We kept track of those deadlines on a board so we made sure we could get information to them as fast as possible. That's what you have to do in these situations."

Robison suggests that EMS problems with media are common. "We didn't get the coverage we deserved. Part of it was our fault because we didn't have a contact, a way to tell our story. That mis-

take will never happen again," he said. (EMSA has since hired a director of public information.) "On an ambulance call, the paramedic and EMT work on the patient. So when the media come to a scene, they don't see EMS personnel working in an enclosed ambulance. When four or five firefighters work in plan view of the media, they get the shot and the public thinks the fire department did it all."

Lindsay suspects public perception involves more than that. "Recognition is a problem in EMS everywhere," he says. "And it's just as bad here. EMSA wasn't invited to many of the events. When the president came, the fire and police departments were invited–EMSA wasn't."

Several street-level medics who have worked at EMSA for years speculate that EMSA's exclusion from the media and from subsequent public events commemorating the rescuers at Oklahoma City comprises part of a fire-department strategy to move into EMS transport. "That was when the [FD] brass pushed to take over the service," said Lindsay.

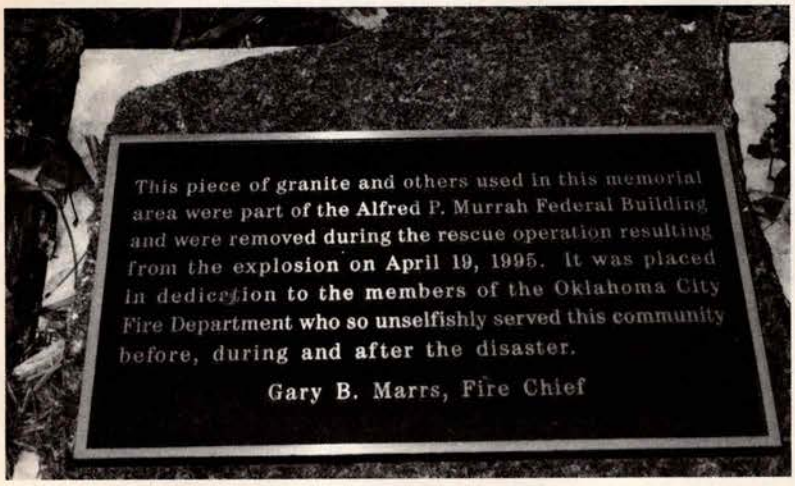
Marrs confirms that such a move is in the planning stages, that the city council encourages the department to take on advanced life support and transport. But he scoffs at the notion that EMSA was deliberately left out. "We had an area where the media was kept and had daily press briefings," he said.

One thing remains clear: The fire department's firm grasp of public opinion placed them in an enviable position. "The public was supportive," said Clark. "There were barbecue dinners–so many you couldn't attend them all. We got letters from school kids around the world. There was stuff all over the department: teddy bears, letters, posters... ."

Assistant Chief John Hansen, the main public affairs officer for the incident, has written a book on the bombing. Officers at the department have spoken about the incident on television talk shows, in fire halls and at conference centers. All of this left Chief Marrs with management issues to ponder. "In January 1996, I had to put an end to city-sponsored time for employees to go out and talk about the incident," he said. "I had dozens of people on the road. At one point, we had a secretary dedicated to doing nothing but scheduling people's travel and time off."

Three years later, Clark has found hindsight 20/20 regarding the media lessons of Oklahoma City. "Start early. Have media relations all the time and not just on big incidents," he says. "Early on, set rules that everyone needs to follow and make sure the media know what the rules are. Also, without an incident command system, it wouldn't have gone smoothly at all. You have to practice incident command on small incidents so you are ready when the big one happens."

For EMS in particular, the Oklahoma rescue was an opportunity to shine. Americans finally saw exactly what occurs during a call—what medical care in the streets is all about.



A plaque honoring rescuers was unveiled in front of Oklahoma City's main fire station.

Nearly three years have passed since the bombing in Oklahoma City. A dirt pile—the beginnings of a monument to the 169 who died, including an off-duty nurse who was killed by a concrete slab while working on scene—marks the location of the Murrah building. A lone tree, untouched by the blast, stands as a subtle reminder of random terrorism and violence. Overall, a certain resolve has descended.

Tourists walk slowly past the site, reading cards and poems still attached to the chain-link fence. The emergency community has settled into a new reality. At the main fire station, few talk about the bombing anymore. And when they do, many sound tired. At EMSA wounds continue to heal.

Analysis of the incident has become an industry. Books have been published, minute analyses of the event have been bound and distributed, classes have been held and lectures given. "We studied it afterward," said Clark. "We had committees, and they had suggestions, such as better tactical response, better communication, practice mutual-aid exercises with other services. Now, I'd say things are back to normal—back to the way they were."

For Holman, Oklahoma City has fundamentally changed. Even on vacation, if he mentions that he works in Oklahoma City EMS, the inevitable questions begin. "Just when you think you are over it, something reminds you that you're not. I'm proud of the job we've done," he says, "but I really want to move on."

Based in Toronto, Canada, Marc-David Munk, AEMT-CC, NREMT-I, writes frequently for JEMS *and* Fire-Rescue Magazine. *He has been involved in EMS for seven years.*