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Terminal Case: The End of Volunteer First Aid

Has New Jersey's long-standing tradition of volunteer first aid reached the end of its life span?

By Peg Rosen | | December 16, 2015

After the volunteer West Orange First Aid Squad was disbanded, its members from over the years gathered for a memorial photograph in front of the squad's castle-like headquarters.
Photo by Erik Rank

The last days of the West Orange First Aid Squad weren't pretty. The castle-like building that once served as the home of a dynamic squad with dozens of members—all volunteers—had become a mere way station. For cops in search of a bathroom; for a smattering of volunteer Emergency Medical Technicians on the night shift; and, mostly, for paid personnel who covered an ever-increasing number of calls as the ranks of active and able "vollies" dwindled.

Once there had been training drills and young volunteer cadets washing the rigs. But in these last days, the break-room carpet became threadbare and fleas infested the couch. The West Orange First Aid Squad (WOFAS) took its final call on August 31. Months earlier, the town's Office of Emergency Management and fire department—eager to free up space for a new command center—cleared out the squad's belongings on the building's second floor and unceremoniously dumped decades of cherished service awards and all manner of supplies in heaps throughout the ambulance bays.

"The old guard invested their blood and sweat running this place," says WOFAS president James Troisi. "In the end, they felt they were sold out by the municipality when it gave all our calls to the fire department." Yet Troisi acknowledges that it had become tough for WOFAS to attract committed volunteers. "The squad," he says, "just wasn't what it once was."

Similar stories are unfolding at volunteer squads throughout New Jersey. In past decades, the squads were a source of civic pride, and New Jersey had one of the strongest volunteer systems in the country. But dramatic advances in emergency medicine have created a need for increasingly sophisticated technicians who can commit significant time to training. And changing lifestyles have made it ever harder to find volunteers who are willing and able to meet those demands. "People used to work closer to home and had employers who would let them jump away from their desks when they were paged for a 9-1-1 call," says 60-year-old Tom Kranz, a 17-year veteran of the all-volunteer Fanwood Rescue Squad. "Young people...come to get free training and something to put on their college resumes. But they just don't stick around."

In their heyday in the 1970s and 1980s, there were perhaps 600 volunteer first aid squads in New Jersey; today there are probably half as many. First aid squads (paid, volunteer or hybrid) are intended to provide basic life support (BLS) in emergencies; they are distinct from paramedics, who are hospital based and provide advanced life support (ALS, such as intubations and intravenous medications) for patients with cardiac, respiratory and other life-threatening issues. New Jersey's two-tiered EMS system stipulates that even when ALS is called, BLS squads are expected to provide on-scene support, as well as transit to the hospital. In reality, approximately 10 percent of calls for ALS in New Jersey cannot be answered by paramedics because there are not enough of these units operating in the state. In such cases residents must rely on BLS for emergency care and transport.

As the ranks of volunteer EMTs have thinned, some municipalities, such as West Orange, have shifted BLS responsibility to their fire departments. Other towns have created hybrid paid/volunteer models or turned to hospital-based or commercial services. In some parts of the state, communities are sharing costs through regionalized services or consolidation of squads. In a good many situations, towns offset their new expenses by billing for service and accepting reimbursements from patients' insurance providers.

But what about smaller municipalities that want to maintain their own local squads? Generally, they are out of luck. "We can't afford to pay staff…and most commercial services won't keep an ambulance here because we don't have enough calls to make it worth their while," says Marianne Smith, township manager of Hardyston, whose volunteer squad disbanded in 2014. "Everyone finds it comforting to think of their neighbors as the ones who are responding to their emergency needs. However, most people aren't able to volunteer to help their neighbors like they once did."

The decline of any civic tradition is always a shame. But these aren't adult softball teams or beautification committees that are in tatters. "These are emergency medical squads that are charged with responding to matters of life and death," says Dr. Mark Merlin, a former volunteer EMT and now chief medical officer of MONOC, the largest provider of paramedic mobile intensive care units in the state. "If most residents knew that their local [BLS] squad was down to about 10 active members who may or may not be available at any given time, they'd say it was unacceptable."

Indeed, in many cases, skeleton staffing and slapdash coverage have led to long response times and confusion when 9-1-1 is called. In Hardyston last summer, three neighboring towns were covering for the shuttered Hardyston squad when Nick Demsak called 9-1-1 to say his 3-year-old son had stopped breathing in his sleep. Paramedics from St. Clare's Hospital in Denville, more than 20 miles away, arrived 35 minutes later to discover that BLS had yet to arrive, and the child had died. The Demsak family doesn't blame the local BLS squads' long response time for the death of Eóghan, who had a rare congenital disorder (and may have already been deceased before they called 9-1-1). But Nick Demsak publicly decried the fact that any resident might have to wait so long for an ambulance.

Local news outlets routinely report such incidents. For example, in July 2013, Francisco Reyes dialed 9-1-1 for an ambulance when his elderly mother-in-law fell down the stairs of her Hasbrouck Heights home, fracturing her skull and injuring her spine. Police and paramedics showed up quickly. But it took 34 minutes for an ambulance to arrive from neighboring Hackensack, since the Hasbrouck Heights squad—based just one mile away—didn't respond. "We know that it's taking patients 20, 30, 40 minutes to get to the hospital on a regular basis in New Jersey," says Merlin, referring to local dispatch records. "Yet we don't have hard data on [statewide] response times and health outcomes because volunteer squads don't have to report quality measures to the state."

The paucity of data is tied to a lack of oversight. New Jersey is one of the few states without a full-time, statewide medical director to oversee its emergency medical system. Unlike fire and police service, Jersey municipalities aren't required by law to provide pre-hospital ambulance care. And the Garden State is one of only a handful of states that does not require volunteer squads to be licensed or regulated.

Self-monitoring is, instead, largely left to the EMS Council of New Jersey, to which about 80 percent of the state's volunteer squads belong. The council requires member squads to meet its basic standards. "But they aren't required to tell any outside agency what squads belong, how many members they have, or what their response times and health outcomes are," Merlin says.

After a blistering Department of Health and Senior Services report in 2007 determined that New Jersey's EMS system was near crisis, the state Legislature passed an Emergency Medical Services overhaul bill that sought, among other things, to regulate all EMTs. Governor Chris Christie vetoed the bill—twice—citing a need for further study. Both times, EMS Council president Howard Meyer cheered the fact that municipalities—"not a bureaucracy in Trenton"—could continue to determine who provides their EMS.

Under existing state law, BLS services that bill for reimbursement must be staffed by EMTs who have completed several months of training and participate in ongoing education. But the state makes no such demands of all-volunteer squads. Seeking an alternative to the vetoed EMS overhaul bill, the EMS Council of New Jersey is backing a new bill that would support initiatives to attract volunteers and require volunteer squads to have at least one certified EMT and one driver on board for emergency calls.

Meyer contends that the previous bill's stringent guidelines—which demanded background checks on emergency workers, two certified EMTs riding in every ambulance, and licensing of every squad—would have been onerous for cash-poor squads already struggling to attract volunteers. He also berates the more rigorous EMT curriculum that was introduced in 2012. "When you make training more difficult, people who might have volunteered say, 'I'd love to help, but I can't,'" Meyer says. "EMS is common sense. I've been doing this for 40 years. I don't need to know how the alveoli work in the lungs in order to put you on oxygen. I don't need to know every body part involved to stop [someone's] bleeding."

Many EMTs—paid and volunteer—grouse that the current EMT curriculum is excessive. But a good number of them part ways with Meyer when it comes to regulation. "Why shouldn't volunteers and paid EMTs be held to the same high standards?" says Christopher Lee, president of the Phillipsburg Emergency Squad, which boasts more than 45 active volunteer members and answers about 3,500 calls each year. "If you can't get to calls quickly, if you don't want to spend time learning about a field that is far more complicated than it used to be, if you don't want to change your freaking ways…then go find some other place to volunteer."

Regulation is also seen as a means of standardizing emergency services from town to town and assuring that all have the ability to carry and use the latest life-saving equipment and medication. This includes epinephrine auto-injectors, which can arrest deadly allergic reactions; naloxone, which can reverse heroin overdoses; and advanced pressurized oxygen devices that assist patients in respiratory distress. "Agencies can only carry these tools if they are licensed and overseen by a medical director," says Merlin.

In other words, where in New Jersey your toddler tries his first peanut and has an anaphylactic reaction could, quite possibly, determine whether he lives or dies. "It's certifiably insane and beyond crazy," says Bruce Nagel, a partner at the personal-injury law firm Nagel Rice, LLP. And since volunteers have "broad immunity under the law," Nagel points out, the chances of winning a lawsuit against them for inadequate care or negligence are near nil.

On a given week, you can drive past bucket-toting volunteer EMTs collecting cash donations at the roadside in Little Falls. A half hour away, Union County is like a different country in terms of emergency response. At Union's countywide EMS headquarters in Westfield, uniformed EMTs pull their rigs in and out of a hangar-like bay stocked with emergency vehicles of every shape and size. Dispatchers field 9-1-1 calls from a high-tech command center. In 2014, the New Jersey Department of Health acknowledged Union County as one of the state's Outstanding EMS Agencies.

While the operation is impressive, director of public safety Andrew Moran asserts that Union Countywide EMS doesn't cost residents extra; expenses are covered by insurance reimbursements. He also points out that his operation, launched in June 2011, hasn't replaced the 14 volunteer squads that continue to operate in his county. "We're here to provide backup and get our ambulances to the scene when municipal squads have trouble getting out," says Moran, gently adding: "From the day we opened, we've been busy."

Further south, Gloucester County regionalized nine years ago when officials realized that residents were waiting upwards of 30 minutes for local ambulance squads to arrive. The county budgets about $3 million annually for costs after insurance reimbursements; so far, it has not