THE BODY SNATCHERS

The way our emergency medical system works in New Jersey, too many people are losing their lives between home and hospital.

by Steven Levy

They are impressive, aren't they? Those shiny modular ambulances, lights blazing and sirens shrieking as they race through the streets to perform the work of samaritans. And you are happy with them, aren't you? When New Jerseyans were polled by the Eagleton Institute, a sizable majority thought their ambulance squads were quick, efficient, and extremely capable of handling emergencies.

And many of them are. Most of them, undoubtedly. But not all of them. In some areas, the competence may not be there depending on the time of day, or the particular crew assigned to answer the call to action. If you were to enjoy the impossible option of choosing when to have, say, a coronary, you would do well not to suffer your heart attack during the daytime. It takes longer to get a crew of volunteers during the day. And if you were to choose where to have your coronary, or your multiple trauma (injuries caused by accident), or your sudden, premature delivery of a baby, you would be faced with a difficult choice. Most certainly you would pick one of the areas served by a Mobile Intensive Care Unit (MICU) staffed by paramedics like the ones you see on such television shows as *Emergency*—but if you are like three-fourths of the people in this state, you do not live in an area served by MICUs. And you would certainly want to be in a town served by one of the ''better'' first aid squads. Because some of them are very, very good. And some are very, very bad. So bad that they have the potential to *worsen* your condition.

Sue Coe

"We did what you call 'swoop and scoop': just throw the victim into the ambulance, don't even check to see where he's hurt. Did I see people hurt or killed by my squad? Let me just say that it was a scandal."

– a rescue squad member

Problem is, you probably don't know how good—or bad—your local ambulance squad is. Of the ambulance squads in this state, a small number are private businesses, a few are run by cities, and the rest, 92 percent, are non-profit, volunteer operations: 560 squads serving almost every non-urban municipality in the state. In fact, 15 percent of all first-aid volunteers in the United States are in New Jersey; the annual state convention of volunteers is bigger than the national one. It is a triumph of the good old American concept of pitching in and helping the man down the road. When it works. But when it doesn't, chances are you will never know. Sometimes it takes a trained eye to evaluate what emergency workers are doing, or what they are not doing. The techniques and technologies of pre-hospital emergency care have improved dramatically in the last twenty years, but some places in New Jersey, as one volunteer puts it, "are still operating in the Dark Ages."

Whom can you ask to find out? Not the government of New Jersey. The state has no control whatsoever over the volunteer ambulance squads. It cannot require the volunteers to be licensed before they perform treatment on you during an emergency. "In this state, it takes 2,800 hours to be a barber, 1,200 to be a manicurist, but we don't require the eighty-one hours of (Emergency Medical Technician) training it takes to save someone's life," says one health care professional. The state is also powerless to assure its citizens that the ambulances they ride in will meet minimum federal standards: having an ambulance inspection is optional, and less than half the squads submit themselves to it. Because of the Highway Safety Act of 1971—which the ambulance squads themselves helped draft—the state cannot "restrict any volunteer and non-volunteer . . . first aid squad of the State in the proper performance of its duties." No definition of "proper" is given.

Can you find out from your municipal officers if your squad is competent? No. Local officials are also prevented from interfering with the "proper" duties of a squad. The squad must turn in to the municipality a list of members, noting whatever training they might have had, but almost no municipality checks up on the validity of the training or the accuracy of the list. Until early this year, the local health officer, if he wished, could visit the first aid squad, inspect the ambulance, check out the services; but a bill signed by Governor Byrne on April 10 specifically exempted the squads from local standards of performance.

The volunteers have their own organization: the 51-year-old New Jersey State First Aid Council (FAC). It represents about 450 of the squads. It is a very powerful organization, devoted to helping "Volunteerism" and furthering the well-being of the squads. It is one of the more successful lobbying groups in the state—although, by failing to register itself or its agents as lobbyists, it is in apparent violation of the 1971 Legislative Activities Disclosure Act. It has pushed through dozens of bills helping the squads, their members, and itself. As a result, the squads enjoy a favored status and must answer to no one. Since the FAC has so successfully exempted the squads from public accountability, you might think that it has taken it upon itself to ensure a minimum standard of competence for the squads. It has not. "We don't see ourselves in the role of policing the squads," says FAC president Bill Reed. "We leave it up to them. Home rule works quite well."

How well? Listen to some of the squad members—who will talk, but only if names are withheld.

"My squad has about twenty regular members. I would say that about fifteen of the twenty are what you would call 'body snatchers.' We're twenty minutes away from a hospital, and it's a bad situation we have here," says a volunteer from Ocean County.

"I just quit the squad in my home town and joined another," says an Essex County first aider. "I couldn't take it any more. We did what you call 'swoop and scoop': just throw the victim into the ambulance, don't even check to see where he's hurt. If you got to the hospital quick, that was a good job. Pity is that the people in the squad couldn't handle real emergencies. Did I see people hurt or killed by my squad? I'd be a fool to tell you. I'm liable myself. Let me just say that it was a scandal. And I had to leave."

"If I were hurt or sick, I'd be afraid to call my own squad," says a Gloucester Countian who works as a paramedic. "They ride around without basic lifesaving equipment, they have members with no training, and some are so incompetent that people have almost been seriously hurt by them. As a paramedic I see a lot of squads, and I'm sad to say that this squad isn't the only dangerous one."

"I've been keeping what I call an 'atrocity file,' " says a squad officer in central New Jersey. "And I've estimated that, in the past few years, first aid squads have killed seven people in this area."

Killed? Who has investigated this? No one. When a victim dies as a result of mistreatment by a first aid squad, it is not a cold–blooded murder but a result of negligence, undertraining, overenthusiasm, or just plain incompetence, all in behalf of a good cause: service to the community. No one can expect perfection from any form of emergency service, paid or unpaid. But is it too much to ask for some basic accountability? As it stands now, members of a first aid squad are protected by a statute that protects them from civil liability in cases where unfortunate results are caused by "acts of commission or omission" during emergency service. Excepted are acts relating to the operation of motor vehicles, but in cases where emergency vehicle accidents have killed people, there is a strange pattern of charges being dropped against drivers of ambulances—even those who violate the most basic rule of emergency service: to deliver the patient to the hospital in a safe and orderly manner. In any case, no one has challenged this "Good Samaritan Act" in court and won a judgment against a first aid squad.

Any punishment or suspension of a squad member who has proven himself incompetent is left up to the individual squad, composed usually of close friends of the offending member. Punishment of an incompetent *squad?* No one has the authority.

It has to be that way. Because they're volunteers. We're lucky to have them. If you make demands on them, they'll quit. We need them.

"If you go into a restaurant and get sick, you want to know why. And we inspect restaurants twice a year to make sure people don't get sick," says Fred Rikert, a health officer in Red Bank and a first aider. "But I'm not allowed to inspect the first aid squad in my town. You go out to eat, you know the food is safe. But when you call the ambulance, you get pot luck."

But they're only volunteers . . . they're doing us a favor.

"Sure, they're volunteers. But they think because of that they're untouchable," says Rikert. "I'm sure that 90 percent of them are trained. But all it takes is *1* percent to kill you. Look at that air crash in Chicago—it only takes one bolt."

But they're doing this for free . . .

"When the siren blows," says Fred Rikert, "don't get in the way. No one checks on them because they're volunteers."

Because they're volunteers. . . .

Does Pauline Becker care if they're volunteers or not? When the Carlstadt (Bergen County) Volunteer Ambulance Corps came to her home to aid her husband after he suffered a coronary, it arrived with a resuscitator that was unusable. "I can't find the key," the squad captain explained. Then, according to policemen on the scene, the squad members first misplaced the stretcher, then put John Becker into the ambulance backwards, his torso slipping off the stretcher, his head hitting something inside the ambulance. The police had radioed ahead to Hackensack Hospital, with its respected coronary care unit; on her own, the squad captain took the victim to St. Mary's hospital in Passaic. There, less than twenty minutes after arrival, John Becker, age 42, was pronounced dead.

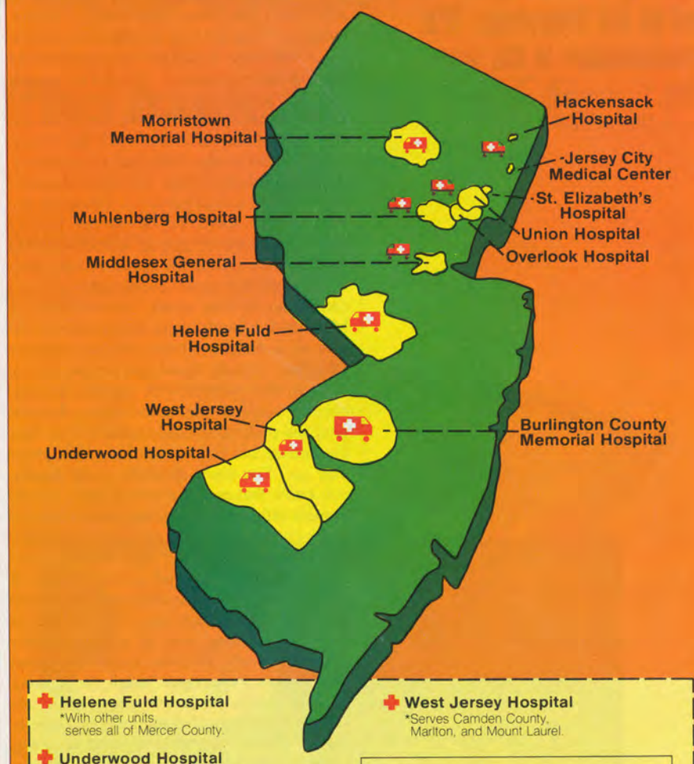
You have to understand them . . .

Does John R. Roy understand? His wife, Marie, keeled over one night after hearing what sounded like gunshots. (They were firecrackers planted by neighborhood kids.) Police investigating the noises began performing cardiopulmonary resuscitation (CPR) on her, and the Fellowship Emergency Squad of Mt. Laurel continued the process. Mrs. Roy died, and her autopsy revealed a bilateral crushed chest, blood and air in the plural cavity, a ruptured myocardium, at least eight fractured ribs, and lacerations of the thoracic aorta, inferior vena cava, and superior vena cava; it was probably the latter that killed her. There was no heart attack. She had merely fainted, and the CPR had killed her.

But we can't ask the volunteers to act as professionals. All they can do is their best.

Whose best was it that John Tittel received? Tittel was receiving CPR while being transported to a hospital after a heart

MICU Pilot Project Areas



Helene Fuld Hospital
*With other units, serves all of Mercer County.

Underwood Hospital
*Serves all of Gloucester County, but will go outside of county if needed.

Hackensack Hospital
*Serves Hackensack only.

Jersey City Medical Center
*Serves Jersey City only.

St. Elizabeth's Hospital
*Serves city of Elizabeth only.

Overlook Hospital
*Serves:
Summit
North Providence
Berkeley Heights
Passaic Township
Chatham Township
Chatham Boro
Madison
Millburn
Union
Springfield
Mountainside
Westfield
Scotch Plains
Watchung

Middlesex General Hospital
*Serves city of New Brunswick only.

Burlington County Memorial Hospital
*Serves within a ten- to twelve-mile radius of Mount Holly.

West Jersey Hospital
*Serves Camden County, Marlton, and Mount Laurel.

*The following three hospitals run independent programs similar to MICU projects, but use doctors and interns instead of paramedics.

Muhlenberg Hospital
*Serves:
Plainfield
South Plainfield
North Plainfield
Piscataway
Fanwood
Warren
North Edison
Dunellen
Green Brook
Scotch Plains
Westfield
Watchung

Morristown Memorial Hospital
*Serves:
Morristown
Morris Plains
Morris Township
East Hanover
Mendham Township
Harding Township
Hanover
Madison
Florham Park
Mendham Borough
*Also responds if needed to:
Long Valley
Chester
Far Hills-Bedminster
Denville

Union Hospital
*Serves:
Cranford
Roselle
Roselle Park
Kenilworth
Garwood
Union
Hillside
Winfield

Leslie Fiis

"All over New Jersey you have little towns within a few minutes of each other, and every one of them has two ambulances, its own dispatcher, in its own building, with a squad room and all the trappings. It's provincialism of the worst kind." – *Nathan Glazer, consumer health care advocate*

attack. The ambulance driver, a member of the Port Monmouth First Aid Squad, went into the intersection of Route 35 and Navesink Road—according to police reports, against a red signal. A 1977 Plymouth, crossing with the green, collided with the ambulance, spun into the center barrier, and hit a third car. Hospitalized were the drivers of the two cars, the ambulance driver, three other squad members, and Tittel's wife. Mr. Tittel needed no hospitalization: he was dead on arrival.

But the devotion these people show is fantastic. To do this in addition to a regular job is absolutely selfless.

It *is* a fantastic thing to give your time to serve your neighbors. And there is an expression, "Bad first aid is better than no first aid." But some concerned volunteers know that this is not always so. It is not *my* squad, they say, but the one a few towns over, the one in the next district, those squads in that other part of the state. Then come the stories. Stories about people in Bergen County waiting forty minutes for an ambulance because there was no one to answer a call during the day. Stories about the Gloucester County squad that failed to hook up a suction unit to the ambulance—and the squad member who watched while a victim connected to the unit choked on his own vomit. Stories about the Monmouth County squad that dropped a patient off a stretcher—twice. Stories about the Cape May County squad that was so low on finances that patients were stacked; the ambulance would detour on the way to the hospital and pick up a second patient. You hear the stories, and you wonder how widespread they are. You know about the good squads, you know that *most* squads, in fact, are extremely diligent in providing quality first aid to the communities they serve. But one story leads to another story, and another. And most end this way: *They covered it up, of course*. There are those rare cases that end in litigation. The Becker case, for example, is currently awaiting trial in Bergen County Superior Court. But the Good Samaritan Law makes these cases tough for a complainant to win. So far, no one has. The accidents are investigated routinely and quietly closed. Tickets are seldom given to ambulance drivers who disregard traffic signals, even though no law permits them to disregard traffic signals, emergency or not. The ambulance driver in the John Tittel accident was not charged. You don't charge first aiders with manslaughter in New Jersey or even accuse them of negligence. After all, they're only volunteers.

And we *are* grateful for them, aren't we? Even though, according to a person who has visited hundreds of them—and who, like most concerned people involved with first aid who cooperated with this story, asked that a name be withheld—the volunteer nature of our ambulance squads have given us not a system but a patchwork, and because of this the fact remains: "You have to pick the time of day, the day of the week, and the place, if you want to survive a heart attack or an accident in this state. Especially the place."

Emergency service is a concept that most people do not like to dwell upon. It is an unpleasant reminder of our mortality. Our towns spend a substantial portion of their budgets on police and fire protection, road crews, and sanitation removal, but do not think it necessary to hire trained professionals to aid their citizens in a life-threatening medical crisis. A victim of a severe coronary must be treated within four minutes for a good chance of survival. If eight minutes go by, the outlook is dim. Experts have noted the irony that of all services reaching out to the community, emergency care is the one capable of saving the most lives. Yet when it comes to funding, we give it low priority. We don't use professionals. We leave emergency care to volunteers.

The volunteer first aid squads do not bill the specific individuals who use their services, but all volunteer squads are funded, ultimately, by the health care consumer. The primary method of funding is by donation: squads send out letters asking a certain sum for "membership" in the squad's community of donors. The charge may be ten, fifteen, twenty dollars, to "protect your family for the coming year." The implication—a misleading one—is that if you do not pay, those in the squad will remember it, perhaps when you need them most. Squads also raise funds by cake sales, direct solicitation, and more lucrative activities, like bingo games. Also, state law permits municipalities to donate as much as $25,000 a year to individual squads, and some municipalities go further by buying equipment, ambulances, and buildings for their squads, renting them back to the squads for nominal fees. The system ensures that no matter where the money comes from, the squads can handle it as they wish—there is never the accountability that exists in publicly owned operations. When the treasurer of an Edison first aid squad was recently indicted for embezzling more than $47,500 from the squad, his alleged thievery was discovered almost by accident. No standard governmental authority keeps track of money that goes to squads.

The savings, relative to a publicly owned service, come in the cost of labor: no one is paid for the time he or she devotes to a squad. But the volunteer system may impose higher costs in other ways. Purchases of equipment are not monitored as they would be in government. "The same squads which don't want ambulance inspections are the first ones to fall for the salesman who's peddling an ultrasonic kazoo. They'll be the first squad in the county with the new gadget, but they don't know if their basic lifesaving equipment is working," says health officer Fred Rikert.

"Volunteers are not cost-efficient at all," says Nathan Glazer of the Southern New Jersey Health Systems Agency (HSA), a group that monitors health care from a consumer's standpoint. "All over New Jersey you have towns within minutes of each other, little towns of a few thousand, and every one of them has at least two ambulances, completely equipped, in its own building, with a

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squad room and all the trappings. And every town with its own dispatcher. Each squad has to buy everything, do everything on its own. It's provincialism of the worst kind.''

''All things work better in a system, and we have no system in New Jersey,'' says Judd Fuller, who runs the communications end of one of the few systematized areas in the state—Newark-Elizabeth. To understand what a lack of a system means, let's look at what happens after you make a call for an ambulance.

Ideally, when you are confronted with an emergency you will dial a well-known number—911, for example—and become immediately connected with a dispatcher who has some medical knowledge and is hooked to an information system telling him of availability of services in a wide area. The dispatcher will evaluate your description of the situation, tell you what to do until help arrives, and dispatch the nearest ambulance, perhaps with police backup. The ambulance personnel, waiting by the rig for such an emergency, will respond immediately.

In New Jersey, only Newark-Elizabeth, Hunterdon County, and parts of Burlington County have 911 emergency numbers. Elsewhere, the number you call may be your local police number, your local fire and ambulance number, or a special number for your ambulance squad. There are literally hundreds of these numbers in the state, seventy-two in Bergen County alone. If you don't know it, you probably would dial the operator, and then *she* would look it up.

Once the call is made, you will probably be connected with a local dispatcher, who may or may not have any medical training. If he thinks you need an ambulance, he will notify the local squad.

The squad may or may not be the closest ambulance to your emergency. Political boundaries, not geography, determine which squad answers a call. Squads serve their own communities first. Sometimes results are unfortunate. A health care professional tells a story about a coronary victim who lived less than a quarter-mile from an ambulance squad, but the squad was across the town line. ''The squad in his own municipality was called, and the dispatcher waited for a crew to respond. Meanwhile, the people in the squad in the next town—who were closer to him, anyway—could hear all this on the radio. But they didn't cross the border for fear of reprisal. You just don't invade someone else's territory. Finally, the dispatcher gives up and calls the other town, tells them to take the call. But before they're out of the driveway, they get called back. 'Forget it,' they're told. 'The patient's dead.' ''

The great majority of volunteer squads do not man their buildings on a twenty-four-hour basis. A dispatcher's call reaches the members at home, from which they must travel to the ambulance. Different towns alert volunteers in different ways. Some local dispatchers use the ''Plectron'' system, which alerts a designated crew by radio. Other towns blow a siren. Other towns use the telephone, calling the squad captain, who must then call around town to find a crew. Minutes pass, and sometimes the dispatcher might have to send a second or third call. After a number of calls with no response, he may then notify a neighboring town's squad, which may have an agreement to ''cover'' in these cases. Then the process will start all over again in the second town. The victim waits.

During weekdays, most volunteers are at their regular jobs, and several calls are frequently sent out before a squad responds. Some squads cannot provide even minimal service during weekdays. In some towns, ambulances are run during the day by policemen or firemen, who may or may not have any ambulance training. Other squads send out half-crews.

It is better to have your emergency in the evening, when squad members are often congregating in their ambulance building to socialize. But do not call too late: the members will have gone home, and your call will be answered by whoever drags himself out of bed. It takes a little longer.

But they're doing you a favor, going out in the middle of the night. And they all have jobs to worry about. Don't be ungrateful.

''The best system is definitely one where people are waiting by the ambulance on a twenty-four-hour basis,'' says Nathan Glazer of HSA. ''The obvious way to do this would be to have towns pool resources, establishing scheduled crews at a central response point in a twenty-mile area. And centralized communications. A 911 call comes in, the crew is responding immediately.''

But you can't ask volunteers *to do that.*

''*Someone* should be doing it,'' says Glazer. ''If volunteers aren't providing our basic needs in emergencies, what good are they? This system isn't free at all. And nobody knows how many people have died.''

Volunteers say that you never get used to the feeling when the call comes in. Your heart starts pumping, you start thinking of what to do next, and then you're off, the red lights freezing the streets in an unearthly red glow, the sirens howling shrill warnings—get out of the way, they say, what's going on here is *real life*. It's hard not to feel that you're the most important people in the world, because to the people who have placed the call, you probably are. Everyone moves away to let you pass, you enter into the house with purpose and urgency, and to the inevitable gawkers you are the heroes who will put things right.

Some calls can make you sick, blood and vomit and sights that you just don't describe. Other calls are routine, especially the most common kind of call, the transports, where you'll take a patient home from the hospital, or move an invalid from home to nursing home. Some calls are dramatic, cases where you must contain a crazy or slap a would-be suicide into consciousness. And some are just plain hard work—lifting a 200-pounder up the stairs in a collapsible Reeves stretcher.

Volunteers also say that it's all worth it. To most, it is the most important activity in their lives. You would think that they would take pains to make sure they were giving the most advanced, most effective brand of emergency service possible. Some do. But some seem to think that the old ways are the best ways. They stick by these ways. Even if it kills you.

It is difficult to characterize the individual squads: some are down-to-business, others engage in jocular by-play that ends abruptly when a call comes, and others . . . well, others are derisively called ''social clubs'' by some volunteers. It is a fact that some ambulance buildings in this state have as a principal feature barrooms where volunteers can unwind with a drink. And politics within some squads can get nasty, sometimes so nasty that personal battles carry over to calls and procedural debates rage on while patients watch. Then there are the squads that do not discourage the ''make-pretend'' aspect of first aid—the volunteers who think that a seat behind the wheel of an ambulance is a license to play stunt-driver, or the first

aiders who suffer from "frustrated doctor syndrome" and do their own, improvised form of first aid.

Was it your town where the squad split in two factions and finally clashed in a fistfight over the question of who would take the rig to the Memorial Day Parade? Was it your squad that took the ambulance to some members' vacation excursion to the Poconos? Was it your squad that tempted a serious accident when it raced through town with lights on and sirens blaring—with the victim not a sick person, but a dead cat en route to the SPCA?

How well a squad's members are trained is a responsibility that rests solely in the hands of the squad leaders. There is an FAC recommendation that volunteers take either the nationally recognized Emergency Medical Technician (EMT) course, or the FAC's own program, the "Five-Point" course. Cardholders of either form of training must recertify over a period of time.

"Instructors have the power to certify their friends in emergency training, and it is an open secret in first aid circles that this power is abused."

No one knows how many volunteers have had either kind of training. The last attempt at a survey was a 1976 Eagleton Institute poll. Response was voluntary, so the results may well have painted an overly optimistic picture. Even so, the poll found that less than a fourth of the reporting squads required either EMT or Five-Point training for volunteers going out on ambulances. The percentage of members who had actually taken the training courses was somewhat better—more than 55 percent were Five-Pointers, and almost 28 percent were EMTs.

How good are these training courses? Well, the eighty-one-hour EMT course is very good. It is recognized by the federal government in all fifty states, it features a coherent system of lectures given by physicians, it includes many hands-on exercises, and it is especially designed for ambulance personnel. To be certified as an EMT, a volunteer must not only attend all sessions of the course but must also pass a test given by an outside expert—not the course coordinator, who might be inclined to give the benefit of the doubt to someone he has come to know.

The Five-Points course is the official training program of the New Jersey First Aid Council—and no one else. Each year, the federal government has refused to certify it as a valid means of training ambulance personnel. Based on the fifty-four-hour Red Cross Advanced First Aid Course (which wasn't designed for ambulance people), the Five-Points program also includes modules on childbirth, extrication, CPR, and defensive driving (the latter module consisting of eight hours of lectures and movies—no behind-the-wheel training). "At no point do they tie everything together," explains one squad leader who has taken both courses. Another squad leader who holds cards in both methods elaborates: "Five-Points asks you to memorize things; EMT training teaches you *why* you do things and makes you think about how to handle emergencies."

"Five-Points depends entirely on the instructor," says a squad leader. "If he wants to give a good course, he'll do it—but sometimes he gets lax, and the course is less than adequate." Instructors have the power to certify their friends, and it is an open secret in first aid circles that this power is abused. "If you've missed a few lessons, some instructors figure you'll pick up what you missed on the ambulance," explains a volunteer. "I've seen people just write up Five-Points cards without giving tests," says another. A third volunteer explains the recertification process in his squad. Instead of giving refresher courses and re-tests, "the instructor calls us in and says, 'Aw, you guys know more than I do, let's go have some coffee.' And he gives us cards."

The majority of volunteers in New Jersey are these Five-Pointers. Less than a third are EMTs. The ranks of EMTs are growing, but this growth is slowed by certain squads that actively discourage their members from becoming EMTs.

"Like a lot of squads, the people in my squad don't like the idea of EMT training," says an Ocean County first aider. "Maybe it's because the state gives the course, maybe because they're afraid that guys who take EMT might know more than they do. Their attitude is, 'I've been here fifteen years and know it all—what are you going to teach me?' Two guys in the squad took EMT training and they were pressured to quit."

Does the lack of training do any harm? More than 95 percent of the calls are not life-threatening emergencies, but on the other 5 percent people with real emergency training are essential. In New Jersey, the people who come in ambulances to answer your call will probably not be EMTs. They may have Five-Point training. They may have no training at all. Nobody is keeping score.

Bill Reed is not bothered by this situation. He seems to think that nothing is wrong at all. Well, almost nothing. There is one snag, you see, just one thing that's keeping Volunteerism from reaching its full glory in New Jersey. That problem is not understaffing, not the lack of central communications, not the lack of mandatory inspections, not the lack of training standards, not the wildly divergent quality of care, not the need for paramedic units. No, there is only one *big* problem. And that is the state government of New Jersey.

Not that the state legislature hasn't been generous to the squads. The Assembly and Senate have been absolutely munificent to Bill Reed's organization, the New Jersey State First Aid Council. Back in 1971, the legislators let the FAC draft the bill that was to exempt the squads from any state control. And through the years, legislators have sponsored a slew of bills aiding the squads and their members. The existence of some 20,000 active volunteers, all willing to vote and act as a bloc, is a fact not lost on our lawmakers. Nor is the fact that a vote against volunteer first aiders is like a vote against motherhood. Thanks to this awareness and the FAC's lobbying effort—an apparently illegal effort, since the FAC is unregistered as a lobby—members of first aid squads are not liable in lawsuits arising from instances of neglect. They are exempt from jury duty. They are exempt from prohibitions against soliciting on highways. They are permitted to attach flashing blue lights on their personal cars. (This has been dubbed "The Kojak Law".) Bills currently under consideration would pay a $25 witness fee to any first aider testifying in a court case; would issue special license plates to first aiders; would require the telephone company to give squads a 25 percent discount; and would permit municipalities to give squads a clothing allowance, a pension system, and even pay the squad's entire budget. Another bill, co-sponsored by fifteen assemblymen, would permit squads to install vending machines that dispense cans of beer in the squad rooms, "but only for immediate consumption on the premises and only to bona fide members."*

Many of the bills pass unanimously. No member of the legislature has made accountability of first aid squads an issue. And no legislator has been more diligent in helping the squads than Assemblyman Walter Kavanaugh (R-Somerset), who sponsored the recent bill that exempted squads from local health "standards of performance" and, thereby, any mandatory standards.

"The squads felt it [standards of performance] was an encroachment on their rights. Who are these health officers to tell them what to do?" says Kavanaugh, a longtime member of the Somerville First Aid Squad and brother of an FAC vice-president. "I think the squads are doing an excellent job of policing themselves," says Assemblyman Kavanaugh.

No, it is not the legislature that worries Bill Reed and the First Aid Council. It is the Department of Health (DOH). Members of the council are convinced that the state is out to "control" them, to put them out of business. "I don't know why, but the state seems to have something against us," says an FAC past president. "They want to get rid of the volunteers—all of us."

No one at the state has any such intention. But in the past, the state has not recognized

*For the record, the fifteen assemblymen and women co-sponsoring this bill are: Dowd, Gormley, Remington, Kern, Edwards, Villane, Orechio, Maguire, DiFrancisco, Olszowy, Barry, Muhler, Weidel, Burgio, and Bassano.

the near-xenophobia of the volunteers. Bureaucrats have been slow to learn that the state is the volunteer's common enemy, representing everything wrong with society. The people in first aid squads are mostly blue-collar or middle-class workers who are very much attracted to the historic origins of the volunteer movement, a movement that harks back to a time before big government, big taxes, and a disheartening lack of control over one's destiny. One reason people join squads is to make a difference, and they see any intervention into their affairs as a direct threat. To do things right, we do it ourselves, they think. Better system or not, they do not want outsiders forcing new methods upon them.

So imagine what happened in 1978 when the Department of Health set up a task force to address some of the problems created by the lack of an emergency medical services (EMS) system in New Jersey. There had been an EMS council, but it was proving ineffective in bringing about the type of EMS system common to almost every state in the country. In twenty years New Jersey had gone from a model of effective, pre-hospital medical care to a laughingstock, simply by standing still. What was once acceptable—

"The First Aid Council did all it could to kill a plan for a statewide network of skilled paramedics — a plan that could have saved more than 1,000 lives a year."

the home rule, home-made form of non-system—was now unconscionably antiquated. And people were dying unnecessarily.

One of the ways the state was lacking involved the use of paramedics—EMTs who had taken extra training (more than 500 hours) to learn what is called Advanced Life Support. These techniques include starting intravenous lines, interpreting electrocardiograph equipment, and defibrillating (giving electric shocks to) patients whose life functions have stopped. Paramedics, especially when they reached a patient soon after a crisis began, could literally bring the dead back to life.

In recent years, the DOH had set up pilot projects of paramedic MICUs. But the nine pilot programs, and the three similar projects that some hospitals set up using doctors or interns instead of paramedics, covered only one-fourth of the state's population (see map, page 75). The task force's Regional Plan was drawn up to extend this service to the entire state. Also included in the plan was a system of centralized communications, and a categorization of hospitals that would identify those capable of handling certain types of emergencies (those with burn units, for example, or spinal cord injury units). The Regional Plan covered only the 5 percent of ambulance calls that involve life-threatening emergencies. The plan was written in a purposefully vague manner, so as not to alarm the first aid squads and the hospitals. (Some smaller hospitals saw the categorization as a threat—they would lose emergency patients to hospitals better equipped to handle specific problems.) The people drafting the plan had high hopes that it would be approved by the Health Care Administration Board, be made official, and would start saving lives.

They didn't count on Volunteerism.

In the late part of 1978 and the first months of this year, the leaders of the volunteer squads allowed rumors to flourish. Rumors that the Regional Plan was not to be taken as read. Rumors that the plan would cover *all* the calls, not just 5 percent. Rumors that the paramedics would be paid professionals who would eventually supplant the volunteer squads. Rumors that it was all a plan to take the squads over.

None of this was accurate. The state's only offense was not involving the first aiders in drafting the plan, a luxury the FAC had become accustomed to in its relations with the legislature. Actually, the MICU pilot projects were proving that first aid squads and paramedics could work well side by side. When a life-threatening emergency call came in these areas, both a first-aid squad *and* a hospital-based MICU, staffed by paramedics, were dispatched. First aiders would do initial treatment, and when paramedics arrived they would use Advanced Life Support to try to revive those whose life functions had stopped. The squad would transport the patient to the hospital. And since it all worked—an estimated twenty-two lives a month were being saved by the projects—the squads could take pride in being part of a more sophisticated system. A minority among the local squads resented the paramedics and refused to call them in cases where they might be needed. But even the most reluctant volunteers were being slowly won over as their squads were given some of the glory for spectacular saves.

This apparently meant little to officers of the First Aid Council. Angered that they had not been consulted, they fought the plan. Meetings held between volunteers and the state turned into shouting matches. Letter writing campaigns produced heated epistles from angry volunteers. Bill Reed's only concession was to try to make a deal with the state: if all references to ambulances were deleted from the plan, the FAC would support it. The state officials did not see the advantages of drafting a plan for pre-hospital care that excluded ambulance service. So Bill Reed sent the word down to his troops—storm the state.

On April 6, 1979, more than 300 ambulances converged on Trenton, where the HCAB was to vote on the Regional Plan. The HCAB concluded that a plan held in so little regard by the first aiders would have

little chance of working. The plan was voted down.

Ignored in all the noise was a study of the MICU pilot projects drawn up by the DOH. Using data from the projects, it concluded that extending the MICUs throughout New Jersey would save 1,056 lives a year.

Twenty people a week. Eighty-eight people a month. One thousand fifty-six people a year. Ignored.

All because, in the words of one council officer, "we didn't want to be any taxi service for those paramedics."

But that particular officer does not answer calls in an area covered by the MICU pilot projects, which have now been declared permanent by the state. He does not know that "taxi service" is only a state of mind, and he would certainly agree, if he thought about it, that a much worse designation is "swoop and scoop." Or "body snatchers." And that the people in his area—in fact, three-fourths of the population of all New Jersey—have a distinctly smaller chance of surviving an emergency because of the defeat of the Regional Plan.

And that this year, a thousand people will needlessly die.

Things have *got* to get better with the squads. And I think they will. At one of those Regional Plan meetings I went to, the people opposing the plan were the squad leaders—mostly men too fat or too old to go out on calls. But at the back of the room I saw the younger volunteers. They looked more eager, more attentive—there was something in their eyes that said, 'Soon things will be different.' "

The speaker is yet another health care professional who fears the squads too much to make his name public. There is some truth to what he says. Many of the squads are experiencing little revolutions in which younger, more progressive first aiders are taking over, requesting state inspections of ambulances, changing squad bylaws to require EMT training, and trying to enlighten the squads around them to do the same. Enough of these, and we will eventually have a *system* of pre-hospital care in this state. "After they defeated the plan, they celebrated big," says one person involved. "But for some of them, what happened afterwards was like waking up after a drunk. What had they *done*?"

They had guaranteed, in the words of one expert, "that people will be crippled, people will be maimed, and that people will die." And waiting for a new generation of first aiders to take over is not good enough—if it is you, or your spouse, or your child who suffers because of inadequate or careless treatment.

Maybe this article does not apply to your situation; you might well live in a town with a well-equipped, effective, well-trained first aid squad, backed by one of the MICU projects. But even then, on weekends or country drives, you will be traveling through other towns, towns where you may never be sure

who or what will answer your call for help.

Can people be sure in Clayton, a town of 5,800 in southern Gloucester County? Several members who have left or have been forced to leave the Clayton First Aid Squad say no. They tell stories about calls that almost ended tragically. Of a "driver-training" program that consists of taking the ambulance for a spin around the lake, and of drivers so reckless that the ambulance had to be stopped and a driver forcibly replaced. Of calls where patients were refused service because a squad official didn't think they needed an ambulance. (On one of these calls, the other two squad members had to convince a nearby policeman to make the official request for the ambulance—a good thing, since the patient suffered a massive coronary at the hospital). Of entire days going by without trained people on duty. The ex-members, and some people still in the squad, both have a personal list of horror stories, and both believe that the quality of emergency care in Clayton is frightfully inconsistent.

The concerned squad members outlined, detailed, and documented their complaints, and sent them off to the Department of Health, hoping that action could be taken before someone was seriously hurt. The state, of course, is prevented by statute from interfering in matters involving first aid squads, even in potentially dangerous situations. Nothing was done. So the members resigned, or were thrown out of the squad for their vocal opposition, or stayed in the squad and kept silent.

The squad president, John Rogers, bears the brunt of most of the complaints, and during his presidency at least two dissident squad members were driven out—even though members of the squad say that it is now difficult to fill out duty crews. He describes the stories of botched calls as "nit-picking," and he attributes the entire controversy to local politicking.

On July 14 of this year, months after the state's refusal to act, John Rogers heard the siren indicating an ambulance call. It was a Saturday, and no duty crew was scheduled. It was first-come, first-take-the call, so John turned on his radio, heard that the call was a drug overdose, and decided to drive to the ambulance as soon as possible. On his way John Rogers hit two boys, ages 8 and 13, who were riding their bicycles and could not avoid Rogers's car. Rogers was cited for reckless driving—he later fought this in court and won, nullifying the ticket—and both boys were hospitalized. "I was just going too damn fast," says Rogers. "But I was not guilty." Rogers still answers calls for the Clayton First Aid Squad, and no official body has investigated the charges of the dissident members.

"I think that our squad does the people of Clayton a great service," says John Rogers. "I know for a fact that we've saved some lives. If we do a lot of things wrong, if we don't do things right, so what?

"We're only volunteers," says John Rogers. ■