

HISTORY'S STEPCHILD: EMS IN AMERICA 1960 to the Present.

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Writing or teaching contemporary history is a hard thing to do. The author or teacher invites scorn from scholarly minds because the events and people being written about are for all intents and purposes a species of current events. Less pedantic souls see contemporary history as the affirmation of some borderline religious truth. It happened. It had to happen. It was God's will. Ardor, awe and terminal blindness combine to delete the misdeeds and half-truths of the unconverted. Shouting, pouting and hawking various missals serve to bring about the apotheosis of the chosen.

WHY SHOULD ANY OF THIS MATTER TO EMS EDUCATORS?

Suddenly and without much warning the Hippie Generation EMS pioneers and their Yuppie and Generation X successors have awakened to find EMS classes full of post-modern men and women. The EMS business as most of us construe it has been a factor in American health care and public safety since 1960. The average eighteen year old EMT student or twenty year old paramedic student actually deigns to wonder where this exciting albeit frustrating vocation came from and how did it come to be the way it is at this juncture.

Associate and Bachelors Programs in EMS are feeling increasingly obliged to give these inquiring souls an answer. Modern EMS students want an answer. The whole matter seems simple enough. The average EMT, Paramedic or EMS instructor need only put two weeks to four weeks worth of modules in the course syllabus and put the baby squarely to rest. A popular movie can be shown. An encyclopedic little orange book can be assigned. Clearly, it ought to be done and done well because it might inspire and sustain EMS students during the long haul from training to re-certification. Instructors could and maybe should use the historical background of the emergency medical services field as a platform from which to summon up useful war stories—stories that hint at how we did and still do it out in the field.

WHAT CONCEPTUAL PROBLEMS ARISE IN THE COURSE OF TEACHING EMS HISTORY?

How does one go about teaching EMS History without making it a formal catechism? What actual concepts and apparent facts bear on the way EMS is practiced in America right now? What information is lacking?

Ideological gobbledygook hampers any cogent and conclusive attempt to answer these questions for all time. EMS has numerous tribes. Each tribe has a measure of justifiable pride in its accomplishments. The truths of Public Safety and more specifically Fire EMS blunt those of Volunteer EMS in a rural setting. A well heeled hospital operated Mobile Intensive Care Unit Program in the Northeast can dwarf the very real accomplishments of a high performance fleet ambulance system in Washington or Oklahoma. In Florida, one can cross a county line and find stark contrasts in the EMS configurations of bordering resort communities. There is no one way to do EMS in America. If Medicare has mandated the scope of medical transportation to the extent that ALS 2 means the same in Vermont as it does in Philadelphia, then the same cannot be said of direct emergency care. Our embrace of the emergent and critically emergent patients is affected by patient mix, monies available and, oh yeah, institutional histories.

CORE CONCEPTS

ONE. Cardiac emergency care has a distinct history of its own dating back several centuries to Europe and England in particular.¹ Europeans were troubled by young lives being lost to drowning

accidents and other sources of sudden death. They experimented fairly widely with bringing back cardiac and respiratory emergencies from such deaths. Physicians in the United States carried through the legacy of the Europeans in Baltimore, Pittsburgh, and San Francisco. Ambulances were the means EMS used to get to the cardiac or respiratory emergency cases.

TWO: The scientific orientation of the 1960s facilitated a systems approach to emergency care system organization and design.² American Science focused primarily on death stemming from traumatic injuries. Auto accidents were seen as a long neglected disease. The disease was something Americans could combat successfully if they were scientific and above all systematic about it. Trauma was something akin to putting a man on the moon or holding back the tide of Communism.

THREE: A creative and at times frightening federal emergency care program rooted in Public Health made EMS take on a definitive cast in the 1970s.³ The Federal Government's Regional Medical Programs created a climate favorable to a full-scale entitlement program for a full-scale entitlement program in EMS. From 1974 through 1982, the Title 12 EMS Administration strove to standardize and change the logic of emergency care response systems. The severity of a patient's condition dictated the choice of hospital for that patient. Hospitals and their physician staffs were functionally qualified to care for certain types of patients or they were not. The last truly national effort to erect a wall to wall 304 region EMS systems fell out of favor with Congress, the President and some of the country's citizens in 1982

FOUR: An equally creative and often intimidating movement colored EMS dispatch in the 1980s and beyond.⁴ Jeff Clawson brought algorithms and systems logic to their fullest fruition by reducing EMS dispatch to serious of proven patterned responses. Three dozen or so cards held in the hand or on screen elevated a dispatcher to the level of medical control agent. The person answering the phone needed CPR training but little more. CPR was needed for giving instructions over the phone. Millions of patterned responses took place because of the priority medical dispatch movement. Influential EMS providers backed it or joined it outright. Congress rejected it as a standard in the later part of the 1990s but the fight for logical, systematic and nearly error free dispatch modalities goes on.

FIVE: The health care finance bureaucracy in Maryland has had an enormous impact on the development of EMS since the 1960s and on into the present century.⁵ EMS began by hooking ALS care on to Part A Medicare expenditures for hospital based mobile intensive care. As the population grew older, and heart problems presented more frequently, a more formal list of charges and add-ons were built into most ambulance service reimbursement schemes. The 1990s saw the intrusion of HMOs or managed care arrangements in which some debate arose as to who will pay for medical supplies and services for emergency patients. Direct care for multi-systems trauma cases or complex out-of-hospital cardiac arrests ceased being a funding priority at the national level. The population had asthma, COPD and hip fractures more often. EMS work was concerned with people who were not in imminent danger of dying in one, six or even twenty four hours. In light of the change in the patient mix, medical transportation is more or less what the financiers and the bureaucrats would prefer to have urban and suburban EMS folks deal with much of the time. There are exceptions to the rule. From 1997 through 2001, the rural areas of the nation were exempted from this redefinition of EMS's role. Special financial incentives were awarded to services transporting patients out of extremely rural areas. On an overall level, it can be said that most services provide medical transportation to pay the bills associated with direct care. Fire officials are coming to grips with billing too. A fluid environment persists as we redefine the role of EMS in the public health system. There are requests that are ALS even though they are BLS; specialty care

transports made in tandem with paramedic intercepts and other elements of a work environment in which the system micromanages what some disparage as taxi runs. Medical transportation is an operating environment in its own right.

EMS 2002 VERSUS EMS 1960, 1970, 1980, 1990 AND SO FORTH?

Hopefully, students with a firm grasp of these five concepts will be able to navigate the sometimes troubled waters of EMS survival as well as or better than some of their unit administrators. If so it will be because they have given up on the age old, quite natural and utterly futile exercise of drawing a line from point A to point Z and proclaiming events the logical outcome of EMS History. There is after all more than one EMS History. The cardiac emergency care spectrum had its origins elsewhere and much earlier than we might have thought back in the 1960s when CPR first took hold. Trauma EMS Systems had a different genesis. They come from the Korean War, the Vietnam War, A Neglected Disease, Dog Labs in Austria and later Maryland and the indomitable cutting docs who emerged as romantic heroes on television and elsewhere until the tab got too high back in the real world.

It is also probable that volunteer EMS, fire EMS and private EMS are very different in significant ways. We are only beginning to study how they differ. All EMS systems or subsets of systems shared the mighty embrace of Title 12 in the 1970s. The federal government refused to pay grant monies for EMS systems development unless hospitals were rated as to their capabilities for handling various levels of patients. Pre-hospital systems were to be configured so as to deliver the sickest patients to the most well prepared facilities. Many loved the experience and still regard it as a righteous crusade. Others hated it and go out of their way to deny it ever happened. It was the last attempt to organize a coherent national EMS system for America. Nothing has happened since then to equal it in intensity or the emotions pro and con it inspired.

The absence of a federal government presence was considered by many to be a good thing. National authorities of any type met with resistance. An offshoot of the systems revolution was the vital, technocratic and somewhat mystical Emergency Medical Dispatch Revolution of Dr. Clawson out in Salt Lake City and elsewhere. It married technology, medical control, public safety and public health. It had a distinctly messianic air about it in instructor training academies. Students of the new philosophy felt special. Some of the ritual jewelry (e.g. orbs) were much prized among the membership. For ever forty million dispatches, there were but a handful of real or imagined lawsuits. It was dispatch with flair, style and technical sophistication behind it. Congress resisted making it the prevailing system in the land. Certain towns do too.

Tax supported EMS was and still is a rarity. Public utility models in which the citizens subscribed to EMS annually or paid into a kitty to support its existence found it tough going in the 1990s. Medicare set the standard for most other insurance payors. EMS services had to bill Medicare for transportation work just to set aside a hard money reserve for operational purposes. Fiercely independent ambulance companies came to provide Medicare with computerized bill submissions and learned to swallow capricious mileage reimbursement rates that culminated in what was often a no win situation. Medicare set the rates. Ambulance providers tried hard to swallow them. Fewer and leaner ambulance providers survived. Fire chiefs ventured into EMS and commercial services sought and got direct service contracts in urban areas.⁶

The logic of events between 1960 and now shows that outside influences matter in EMS. A country with a hardy distaste for big government repudiated the public health EMS initiative and the EMD movement. Lower taxes and less bureaucracy are popular ideals. It seems clear that these ideals

have changed our preoccupation with direct service modalities in EMS. Hidden taxes and seemingly unconcerned bureaucrats dictate the scope of our labors in the burgeoning field of medical transportation. We get paid to transport people who'll very likely die in the next two years. Society wants us to do that very thing. We have trouble getting paid to fix a multiple gunshot patient or cardiac patient eight miles away. The challenge remains open to us to try and do both.

¹ Mickey S. Eisenberg, *Life in the Balance: Emergency Medicine and the Quest to Reverse Sudden Death*. New York: Oxford University Press, 1997.

² Carl J. Post and Marsha Treiber History in A. Kuehl (Ed.) *Pre-hospital Systems and Medical Oversight*. Dubuque, Iowa: Kendall/Hunt 2002, 3-19.

³ Carl J. Post, *Omaha Orange: A Popular History of EMS in America*. Boston: Jones and Bartlett, 1992. (Second edition 2001).

⁴ Carl J. Post. *Essays in the History of EMS: EMS Folk Workbook: COMMUNICATIONS*. EMS Village Library. <http://EMSVillage.com> (May 2002)

⁵ Stuart Altman et. al. *The Future U.S. Health Care System*. Chicago: Health Administration Press, 1998; <http://www.nrharural.org/dc/summary.html> ; http://www.chems.alaska.gov/ems_billing.htm ; Carl J. Post, *Careless History: Part Four: Bush's bizarre renaissance*. *Responder* September 2000, p.29; Michel A. Sucher, *Private*. in A. Kuehl (Ed.) *Pre-hospital Systems and Medical Oversight*. Dubuque, Iowa: Kendall/Hunt 2002, 75-80.

⁶ Jerry Overton and Jack Stout. *System Design*. in A. Kuehl (Ed.) *Pre-hospital Systems and Medical Oversight*. Dubuque, Iowa: Kendall/Hunt 2002, 114-131.