presented. The information published was taken from the survey form returned to us by someone presumably in your unit. Unfortunately, staff and time constraints made it impossible to follow up each respondent with a telephone call to confirm the information. You are right that we should have noticed the incorrect area code for Vermont, however the majority of the survey was conducted during the summer months and many of our respondents gave their home telephone number which may not have been on or near the actual campus.

As I mentioned in the article, this was the first attempt at reporting the activity of student-operated emergency services, as well as an attempt to provide a list of existing units. We anticipated some errors but responses such as yours will serve to increase the accuracy of this information as well as expand upon it. We have learned of several other squads that were also not included. So, to the extent that my goal was to increase communication with and between college-based services, I feel we succeeded.

Thank you again for taking the time to provide us with this valuable information. I wish you continued success in what I personally know to be a very difficult undertaking.

The Great Debate

I am a private sector paramedic working in Portland, Oregon. I used to be amused by the ongoing debate between Jack Stout and Dennis Murphy on public vs. private EMS. I have lived the better part of a year suffering through this debate in real living color. The stress of the job and now, the added stress of this political jockeying, is becoming taxing. To have to sit, month after month, and read about what all of us here in Portland have been experiencing is annoying.

It's obvious that there are advantages to both systems and, depending on the resources available, both can be cost effective. Your point of view is probably going to be dependent upon who gives you your paycheck.

Both Stout and Murphy are very knowledgeable people. Let's see them get together and discuss solutions to problems that plague both systems and cause the costs to rise; such as: 1) system abusers – those persons who call for ambulance transport, and admit, "You have to pay up front for cabs, you don't for ambulances," and have no real medical need; 2) welfare systems that pay less than one-third the actual cost, or not at all for justified medical care and transport; 3) medicare that pays on last year's profile or not at all for persons not surviving 24 hours after service; or 4) a public that has grown to expect a multi-million dollar system to cost pennies per transport.

These are the real issues driving up the cost of the systems, not who's providing the service. So why don't you tackle these issues instead of questioning what will still be debated long after we're all retired.

Kevin F. Sweeney
Aloha, Oregon

Jack Stout replies: *I know how you feel! The systems I have helped to develop receive little or no local tax support. Thus, I too must contend with system abusers, token third-party reimbursement, and consumers who crave subsidized rates but not the subsidy.*

But I must point out that the public/private debate is about these issues. Every Medicare victory our industry has won can be attributed – not to intervention by government-run EMS programs – but to the work of the American Ambulance Association (AAA) and its membership. Payment for ALS services, the separate ALS charge screen, the all-inclusive ALS rate, the postponed application of the freeze last year, and most recently the defeat of HCFA's "lowest common level" (LCL) proposal . . . all were battles fought and won by our industry's private sector with damn little help from our socialized sister systems.

For that matter, if Al Riechle (Springs Ambulance Service) and a handful of other private operators hadn't fought a last ditch battle more than 15 years ago, ambulance services might not even be included among Medicare and Medicaid benefits today.

The truth is most government-run EMS services (Murphy's is a rare exception) don't

want third parties to pay the fair and reasonable costs of ALS services. If such reimbursement were available, how could they justify the additional subsidies they would still need to stay in business?

Practicum Challenge

The presentation of a patient with torsade de pointes (February 1987 *jems*) included some startling observations. We are told that securing intravenous access proved to be very difficult, quite clearly evident in that "multiple attempts were made on both arms, both external jugulars and both femoral veins, all without success." What kind of physician medical control would permit this to occur in the field? How much time was expended in these repeated, and fruitless, attempts to place an intravenous catheter in a patient whose arrhythmia had responded to a precordial thump? Furthermore, pharmacologic anti-arrhythmic drugs, including lidocaine, are contraindicated.

The decision to intubate the trachea in order to provide a means of administering lidocaine in this setting is also questionable at best, since even 2 mg/kg injected by this route will require nine to 15 minutes to reach blood levels at the very lowest range of those necessary to suppress ventricular ectopy.[1] These facts, particularly the multiple attempts to establish an intravenous route, suggest to me that physician medical control was inadequate.

This medical condition in this specific circumstance did not warrant such excessive time consumption. I am a strong advocate of the institution of intravenous therapy by EMT-paramedics under standing orders in a physician medically-controlled system,[2] but I am increasingly concerned that uncontrolled and flagrant abuse of this intervention in medical emergencies will lead to indefensible consequences comparable to those which have occurred already in traumatized patients. It is a solemn and not at all premature reminder that medical control in prehospital EMS had better descend from its high-horse and exert its mandatory influence in day-to-day emergency care in the field.

Roger D. White, MD, FACC
Rochester, Minnesota

References

1. Viegas O, Stoelting RK: Lidocaine in arterial blood after laryngotracheal administration. *Anesthesiology* 43:491, 1975.

2. Feldman R: IV line placement: A time study for prehospital providers. *jems* 11(8):43-45, 1986.

Mike Taigman/Syd Canan reply:
Reader reaction to the multiple IV attempts was not unanticipated when we chose this case for publication. We chose, however, to present the facts as they occurred and address the concerns they raised. We would like to thank Dr. White for sharing his expertise with us. We agree with the need to address the quality assurance and medical control problem raised. As a matter of fact, the particular agency from this practicum is instituting a new quality assurance program to address day-to-day issues such as this.

Dr. White has raised some core issues that any individual or system providing ALS services should evaluate. In addition, his insights about the tracheal route of lidocaine administration are appreciated. One of our goals in presenting "Cardiology Practicum" is to not edit our controversial subjects or mistakes. We feel that raising a little skepticism and occasional anger can be platforms for collective learning and development. We encourage comments, questions, criticisms, or clarifications to any of the cases we present.

Any reader who has prehospital cardiac cases to share for possible inclusion in "Cardiology Practicum," should please send them with as much detailed information as possible and with original EKGs (if possible) to jems, *P.O. Box 1026, Solana Beach, CA 92075.* □