



# VITALS

for Medical Transport Professionals

A Weekly Safety Newsletter

## ATTRITION

THOMCO recently received a report from a client in a small county ambulance operation in the rural Midwest telling us that turnover is worse than it has ever been. Surprisingly, the client said that he is no longer in competition with Fire Departments for personnel. Some of his more experienced medics have taken academic bridge programs to become nurses and have gone to work in ERs and ICUs. The nursing shortage created an impetus for legislative action that made the transition from medic to nurse easier. The medics who became nurses work fewer hours, but increased their income by about \$25 thousand dollars a year. Financial pressures, such as those seen with poor reimbursement, won't allow him to compete. The most startling thing he said was that many of the new people who are drawn to EMS come to it with the stated intention that they will do it as long as it is exciting and fun. Money is a secondary issue. About a week later, the Victorville Daily Press, in California, ran an article about EMS providers which ended, "As long as the public perceives our job as this great exciting thing, there will always be brand new kids lining up and down the block willing to work for free." To get the same information from the middle of the country and the West coast at about the same time seems more than coincidental. What are some new and surprising or old and seemingly insoluble issues with recruitment? Send your thoughts, failures or successes to [meszcygiel@thomcoins.com](mailto:meszcygiel@thomcoins.com). We'll compile them and report back to you.



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## ENDOTRACHEAL INTUBATION: Part 1 TO TUBE OR NOT TO TUBE, SHOULD THAT BE A QUESTION?



When most of us read this caption, our thoughts go to the clinical indications and contraindications for endotracheal intubation (ETI). The question in this case requires us to take a step back and ask, "Should our service be doing ETI?" Although our vehicle claims exceed our malpractice claims by about a 25:1 ratio, malpractice claims are usually catastrophic and many times the result of a real or perceived bad outcome associated with ETI. Wang Et Alia published "Procedural experience with out-of-hospital endotracheal intubation" in the August 2005 Critical Care Medicine 33(8), pp.1718-1721. Wang wrote that ETI "requires great skill to perform in order to reduce the likelihood of adverse events such as airway injury, inadvertent oxygen deficiency, slowed heart rate, and death." Researchers looked at the Pennsylvania EMS database for 2003 and analyzed 1,544,791 patient care reports. 11,484 ETIs were reported. The intubations were performed by 5,245 medics. 67 percent of the medics performed 2 or fewer intubations. More than a third of the techs did not attempt any intubations. How good are any of us going to be at something we do less than twice a year? Is our initial training so good that we can anticipate long term skill retention? Is mannequin practice enough? More to come.

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