

NYC Emergency Medical Services Periodical

EMSBANSHEE

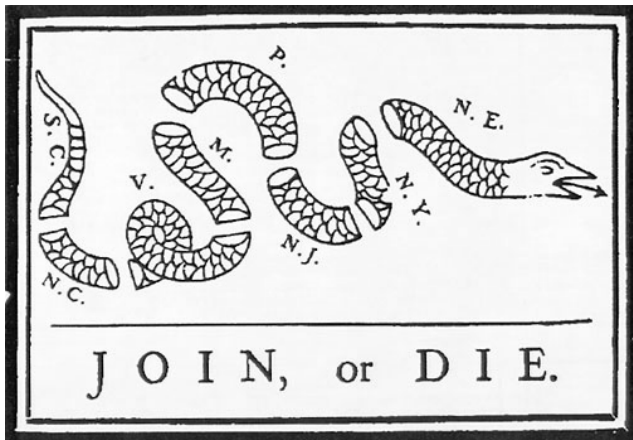
Volume 1: Issue 3

PRAY FOR THE DEAD , FIGHT LIKE HELL FOR THE LIVING

November



AMBULANCE
FIRST-TO-GO



NYC Emergency Medical Services Periodical **EMS BANSHEE: TIME TO GET ORGANIZED**

Volume 1, Issue 3 November 2009

PRAY FOR THE DEAD, FIGHT LIKE HELL FOR THE LIVING!



EMS BANSHEE STAFF EDITORIAL BOARD

Chief of Staff: Walter Adler

Chief of Operations: Jon Saltzman

Chief of Private Distribution: David Briscoe

Chief of Municipal Distribution: Chris Jacobs

STAFF

Layout/Design: Jon Saltzman

Accountant: Mike Allamby

Advertising Sales: Hasan Askari

Legal: Marcy Gordon

WebMaster: David Barbosa

DISTRIBUTION COMMAND

Manhattan Captain Municipal: Ellis Olive

Manhattan Captain Private: (position available)

Bronx Captain Municipal: Danny Madrano, Leon Goldson

Bronx Captain Private: Kathleen Pagano

Brooklyn Captain Municipal: Thomas Ansu, Gladys Guerra-Santiago

Brooklyn Captain Private: (position available)

Queens Captain Municipal: Cosmo Jackson

Queens Captain Private: (position available)

Staten Island Captain Municipal: Johnny Emmington

Staten Island Captain Private: (position available)

Letter to the Editor:

First I would like to thank you for remembering our fallen brothers and sisters that we lost on September 11, 2001. It is with some sadness that I must inform you of two errors in your list. First is the listing for Andre Fletcher, Andre was a Paramedic who worked rescue 5 and also was my part time partner at Maimonides Medical Center. Andre was proud to be a Paramedic and I know this oversight was unintentional. The second was the failure to list James Papageorge. James was a Paramedic and FF and I had the pleasure of being his preceptor during his ALS clinical rotations on my ambulance.

I enjoy your paper and encourage you to keep writing the truth as we all live it. Thanks again for your hard work and effort to open the eyes of all EMT/Paramedics that work FDNY, Voluntary, Volunteer and Proprietary units. - Christopher Welsch EMT-P

Demands of the New Commissioner

Let us make it plain, regardless of who is appointed to the position of Fire Commissioner, our demands remain the same. We say demands, not requests because those with nothing, not even a living wage for our highly profitable toils are in no position to be patiently making requests. We hear the PBA and the UFFA; the power house labor unions of Police and Fire Suppression make war cries over whether their men and women have to pay into pension, or whether their salary will jump from start pay 70,000 to start pay 80,000. Their demands and their requests, when compared with our own, are to pit the claims of further appetite versus those of starvation.

Compared to Fire Fighters and Police we are a rabble, politically and economically speaking. While an estimated 12,000 women and men hold the EMS blue card in the Tristate area, no one speaks for us collectively. We are unable, and apparently unwilling to throw votes and money into political races so we reap the benefits of more of nothing. Listen to the votes of 38,000 Police officers and 12,000 Fire Fighters and their children and spouses for change and these are suggestions the New Commissioner might listen to. But we have demands. Let it be stated again, as the simplicity prevails, We need parity with NYPD and FDNY.

In simple terms all objectives and tactics in our struggle as a work force may be summarized as such: We require a 20 year Pension, we require base entry position pay equality, we demand reinstatement of promotional exams on all levels of command, equity in our benefit package and civil service status established before hiring. That is to say, what the other two services have possessed for years.

The Commissioner must understand that if we are not given these things we will grow critically distressed and we will grow bold. We will become not a tale of a young service given the respect its due in proportion to its municipal contribution, but instead a political liability.

We are the life savers, as we must always remind the public and ourselves. We are not the trash collectors, the law enforcers, or the fire suppressors; our job is to always be there when the public falls down sick, injured, maimed or broken. Lest we forget there is a green cash money side to things. Other than Traffic Enforcement, no single city agency generates near the green cash money we generate in revenue each day. To the ballpark figure of \$473.00 for a basic, no frills BLS transport up to nearly a Grand for ALS work, each day our units bring this Department many tens of thousands of dollars in revenue which certainly does not seem to trickle back down to us.

We see that most Police Officers and Fire Fighters own homes in the five boroughs, hold second jobs often at a business they own, have happy marriages and can put their kids through college. Can the same be said of EMS? The answer is 'hardly'.

Honoring promises to construct new facilities, replace antiquated accident prone equipment like the two person stretcher and the stair chair, renovation of our tenement training facility and the more expeditious maintenance of our fleet. There is a laundry list of desired changes we

can suggest/request later. But now is a time for urgency. Our women and men generate your revenue with their blood, sweat and tears, they pay into a pension they may never see for 25 years. Yet rates of injury and extended LODI leave do not come close to those of the other emergency services. Beyond that gut, visceral reaction that the life savers are being paid like pizza delivery boys or a simple look at the state of the EMS union; times are lean it's true, but we are pulling more than our weight.

Civil service titles may be stripped from us right under our noses. This pandemonium over boots and the efforts to grind us under heel are moving faster than you know. To not mince words, a fireman knows every single gain EMS makes is a dollar less for them, as sad as that paradigm is. But we are not in a position where we can bandy about waiting for another measly 4%.

We walk a fine line, but let us make it plain; **WE HAVE DEMANDS and we MUST organize and struggle until they are met.** Whoever is appointed as the new commissioner must know that we are not a playing card in his deck, we are a powder keg of despair and frustration. You cannot ask a woman or a man to toil for 25 years of their life and keep telling them 'they are special', 'they are heroes', and they are 'moving at the speed of life.' This city loves us, and it will rally behind us. If the city knew the truth about the conditions in which we toil, and the luxuries a fire man enjoys they would support our aims and our struggle.

In conclusion, there are human wants and human needs. A want is perhaps not to be based out of former single engine fire house hand-me-downed to EMS after the suppression boys were upgraded (17, 55, 44) or for that matter to be based next to a medical waste/trash extraction center (35). A want would be for the dangerous apparatus they tell us is called the 'two man stretcher' be systemically decommissioned and replaced with the current standard. A want would be to have leaders promoted based on merit.

Alas, we are now in times of need. We will not slave for 25 years, break our backs, scar our minds, poison our relationships, lose our ideals, lovers and friends to keep 12,000 firemen with rights, privileges and pay we don't come close to enjoying ourselves.

The new commissioner, if he ever reads a Banshee paper in his life would do well to heed these words; EMS has been beaten, mismanaged, underappreciated and almost broken. Be forewarned, broken women and men have very, very little to lose.

Commissioner we have simple demands, must we once again prepare to fight for them?





Fire & EMS Fraternal Societies

Vulcan Society FDNY

Fire Fighter Jon Combs:
718 778 7978

FDNY Ner Tamid Society

Stephen Klein
435-2 Willow Road East
Staten Island, NY 10314
(718) 494-2927

EMS Pipes and Drums

www.fdneyemspipesanddrums.com
John Manning: 917 589 0047

FDNY Emerald Society

P.O. Box 186
Island Park, N.Y. 11558
Hotline # (516) 889-2541
billynolan@fdnyemerald.com
www.fdneyemerald.com

Columbia Association

2024 Gerritsen Ave
Brooklyn NY 11229
Buddy Santangelo, President
Columbia Association, FDNY
Buddy@fdnycolumbia.com
www.fdnycolumbia.com

Hispanic Society FDNY

1940 Haight Avenue
Bronx, NY 10461
718-482-3375
griccodiaz@optonline.net

FDNY Boxing Team

917 282 8727 (FF Bobby McGuire)
ronaldvcampbell@rcn.com or
FDNYBoxing@aol.com
www.fdneyboxing.com

FDNY Holy Name Society

Joe Brosi
23-37 207th Street
Bayside, NY 11360
info@fdnyholynamesociety.com
www.fdneyholynamesociety.com

NYC EMS Website

www.nycems.blogspot.com

National Association of Emergency Medical Technicians (NAEMT)

PO Box 1400
Clinton, MS 39060-1400
Physical Address:
132-A East Northside Dr.
Clinton, MS 39056
Phone: 601-924-7744
Toll Free: 1-800-34-NAEMT
Fax: 601-924-7325
info@naemt.org
www.naemt.org

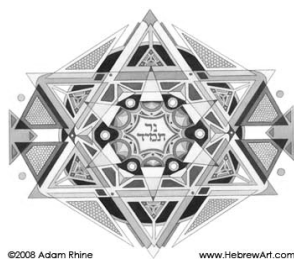
Local 2507: Uniformed EMTs, Paramedics, and Fire Inspectors FDNY

LOCAL 2507 Union Headquarters
47-09 30th Street
Long Island City, NY 11101
718.371.0310
www.afscme2507.org

1199 United Healthcare Workers Union

Main Switchboard (212) 582-1890
www.1199seiu.org

1199SEIU
United Healthcare Workers East



©2008 Adam Rhine

www.HebrewArt.com



1975 - 2000
NAEMT
Twenty-five years of Service



Technician Adler Sings the Blues

“On the value of Organization”

*Written by EMT Walter Sebastian Adler, 37B3,
Station 35, FDNY-EMS*

Oh my brothers and my sisters, how we love to howl for you, how we relish it. We are on the eve of a long hard fight, and a noble one to boot. While the idea of ESU or Fire Suppression may be sexy, tempting or attractive due to adrenaline or green dollars we posit for you a different outlook. As we stand as a service, we are toddlers. We are a new, bold thing. While we have already tasted some bitter defeat and hard struggle, the cards are stacked against us. I tell you the future is ours. It is we who are called to this noble struggle, who devote the best years of our life to the lives of the city we love. It is we who drag the broken out of the trenches and it is we who nurse the fallen back to health. It is we who breathe life and revive the dead. No other service is like ours sisters and brothers. We are not broken; we have just begun to fight.

The Banshee exists because we value life, and the advancement of the life savers. The Banshee howls injustice because we the life savers have been made victims of poor policy, negligent leadership, divisive infighting and an utter break down of morale. But the future is ours to be had.

What other service can boast that the toil of their members is devoted to such a beautiful and noble ideal? The right to life. Everyday our sisters and brothers in these trenches preserve the lives of hundreds and aid the fallen thousands. We are surly and ill tempered, we are skell, we are buff, we are hard, cynical and cold; but we are life savers. In the 8 years I, your less than humble technician Adler has been a life saver have delivered one baby and feel responsible for 8 human saves. 8 times the actions of my partner and I, and normally a medic crew (except in the instance of the baby) were directly responsible for a successful intervention that resulted in the preservation of a life. 8 in 8 years, to us, is trivial. 57 Victor out of Bedstuy must “save” 8 a week. Or 17 Zebra of Highbridge, 20 at least. The point is, among professions, who can say outside of the healthcare industry, “Our sacrifice and bravery has kept not one, not 8, but hundreds of human lives with us.” None but ours.

Now the fight to save ourselves has begun, and it is time to get organized. It is not just the duty of the FDNY life saver to attend 2507 meetings; it is their moral obligation. When our leaders convene a congress or declare a political action we must roll deep. It must get to a point where the Department knows a 2507 general meeting will mean leave time,

bang outs, sick and generally poor attendance.

Our brothers and sisters in 1199 within the Voluntaries must make your voices heard and your numbers count. 1199 must be vested in our struggle. In transport the sisters and brothers organized with in the Teamsters EMS Local must prove themselves and asymmetrical asset. Every trucker, every nurse, every lab tech, every cabby must howl in solidarity for the lives of the life savers and we must invest in every apparatus of labor DC 37, 1199, Teamsters, etc and lend mutual aid to un-organized shop floors where our EMS blood makes some many company mens wallets fat.

There is a further aspect to organization. Looking to both the NYPD and Fire Suppression for blueprints as we always must do, they are flush with fraternal organizations: groups which exist to extend solidarity and aid to each ethnic confession. These fraternal organizations are the solidarity havens one might expect them to be, and each deserves attention. EMS lacks a single organized fraternal organization, and that should soon be rectified, but nothing stops people from joining those of other services. Each has resources, INS, social functions, legal teams, death benefits, life benefits and political connections that must be mobilized to advance the condition of EMS.

Specific to the approximately 3,143 FDNY EMTs and Paramedics, every West Indian or American Black member of service must immediately enlist with the Vulcan Society. Every single Italian in FDNY must immediately enlist in The Columbia Society. Every Jewish or half Hebrew EMT and Paramedic must enroll in Ner Tamid. Each Latino member of service must join the Hispanic Society. As of right now the Emerald Society only accepts fire fighters, our organized ‘fighting Irish’ must lobby to change that. In the private sector and transport (as well as in FDNY) there are sports teams and social networks that must be actively participated in. EMS Pipes and Drum, the Midwood Paintball Team the Gun Medics, the Mi Gente Civil Service Salsa Night, and the Station 35 Bowling Club, and the myriad more we’re missing. There are already Fraternal organizations, clubs and events open to EMS and we must join them and support them in all five boroughs.

The FDNY has a boxing team called (insert) that generates \$40,000 a match to the Wounded Warrior Fund which supports fire men injured and their families. Let’s get some EMS fighters on the team and get some of that green money for our wounded.

‘A gangster is man (or woman) who is organized’ said M1 from the hip hop group Dead Prez. We have to up the gangster. We have to continue to support our unions more proactively, increase involvement in clubs and fraternal organizations

and soon, form for ourselves a true blue, all EMS association that does not place identity on color, religion or creed but on life saving credentials. We look upon the state of EMS and see a war zone; a battle in the months and years to come for the fate of our service. As we discussed last issue, and will continue to pontificate on and cover in this paper; the time is now and the future is ours. Soon, NYPD and FDNY will have to pay into pension as we always have. Soon, 25 and out may be a reality for them. The down economy will always cater to vital infrastructure civil servants, but the battle lines are far from firm or declared. We must continue to insist on 20 and out. We must continue to insist on pay equity with Fire and NYPD. We must insist on benefit equity. We must engage in increased inter-agency and inter-division solidarity between services, municipal, voluntary, commercial and volunteer. These five baseline demands are non-negotiable. We will have no respect and no dignity until the five are made real.

That task falls upon us all. ‘Combination, not competition’ is to be the spirit of the day and in the immortal words of the Industrial Workers of the World, a once powerful trade union founded in 1906; ‘an injury to one is an injury to all.’ So up the unions, up the struggle and dig in my brothers and my sisters because this fight is your fight, and we must all do our part.

There are many easier roads out. Fire fighting, police work, sanitation, nursing, becoming a supervisor, going back to school, opening a small business, even working two or more jobs. We are not one to tell you hard working folk to fight a losing battle. Nothing we ask of you is impossible, but to succeed we MUST now work together. We must pull ourselves up by our PPE straps and prepare for the struggle to come.

We will struggle and fight for a living wage, for honor, for respect, for the lives lost, for the lives broken and torn, for the sleepless nights and fleeting slumber, for the kids, for the new jacks, for the old school, for the crescent, the tombstone, the rod, snake and star. The founding fathers of this nation, in the symbolism of a severed snake urged ‘unite or die,’ EMS: it is time to become organized and do the same.



Red Light EMS under Siege!

by Willem van Leeuwen

Public service workers, for example, paramedics, fire fighters and bus drivers working in the Netherlands are increasingly confronted with aggression and violence. Research shows that in 2008 as much as 65 percent of these workers had to put up with this unwanted behavior. So, compared to 2007, aggression and violence has hardly lessened in spite of attempts to deal with the problem.

Enough is enough. On a muggy August evening in 2008, after a stabbing in Amsterdam-West, bystanders threatened to kill paramedics helping the victim. Their demeanor was so overpowering, that the police had to intervene. According to a spokesperson, the bystanders didn't only interfere with the assistance being given, but also with the relief workers. The paramedics were spat on and the ambulance was damaged. On that Thursday evening sixteen workers, half the paramedics on evening duty, went on strike. They'd had enough. It won them a lot of support and understanding the following day. In addition, paramedics from all regions in the Netherlands warned that they would also go on strike if the violence was not dealt with.

Bystanders harassing paramedics during the execution of their very important work can no longer be seen as a mere incident and it also isn't exclusive to the bigger cities. It is about violence varying from name calling to the threat of physical assault like beating, kicking, spitting and biting. Quite often relief workers have to quickly leave the scene of the accident. In addition, fire fighters are also regularly hindered while performing their life saving work, especially when they have to respond at night. Sometimes they are menaced by elated,

drunk and drugged groups that are drawn to the fiery spectacle. As early as 2006, a large-scale investigation amongst fire fighters revealed that over 25 percent of them considered the serious nature of the violence uncontrollable. Another group that – literally – gets hit, is workers from transportation companies. Nowadays a report about a stabbed, molested, threatened or spat on bus driver won't make the front pages anymore. Their number of work interruptions in 2009 is beyond belief!

The day after the incident that led to the strike action by the paramedics, the Minister for Home Affairs, Ter Horst - clearly outraged - stated in front of the Networks that these offenders must 'keep their hands off government officials'. She called on public workers to report threats and vio-

edics in Amsterdam-Noord were threatened and beaten by an allegedly unwell person. After regaining consciousness, the 'patient' assaulted the ambulance driver and the paramedic with a piece of pipe. He then got into his car and took off. Less than two days later, a 16 year old passenger in a car that hit a tree in Deurne, threatened to assault the attending paramedics if they didn't help fast enough. Fire fighters came to the rescue and removed the boy. While doing so, the boy destroyed an ambulance mirror and verbally abused a police officer.

The growing violence against relief workers is embedded in the discussion about standards and values that has been held in the Netherlands for some years now, about the crumbling tolerance and the ever present feeling of insecurity that large groups of the population experience.

It is starting to look like the traditional libertine attitude of some Dutch has blurred boundaries. As to why this violent behavior is so often aimed at relief workers and public officials, Dr. Menno van Duin, Dean Master of Crisis and Disaster Management at the Erasmus University in Rotterdam says: "Research shows that we often yield to violence and that the ones committing the violence get away with it. In the end, violence, or the threat of violence, has effect. This only increases the problem which is fatal for society."

As to dealing with 'bad-ass behavior', Dr. Menno van Duin says: "It sounds very old fashioned, but in the end it is all about re-establishing



violence at all times and for the relevant organization to try to recover damages from the offenders.

But if her emotional appeal resulted in anything, it is that the problem appears to be far more serious than initially assumed. 2007 counted 7.748 reports of aggression against relief workers, but 2008 more than doubled that number and went as high as 18.000. The enormous increase is largely attributed to her appeal to always report incidents. Some relief workers are by now even obligated to do so.

In the meantime the violence continues unabated. On September 4th of this year, para-

lost virtues. It is just something you need to learn and appreciate once again. So it is justifiable that heavier sentences are already being passed on to those who, for example, insult or threaten government officials while they go about their business. It is also important to punish sooner. In our society we have become so tolerant that people receive six warnings before being punished. An 'immediate response' policy makes more sense than 'turning a blind eye'. This certainly applies to instances of violence towards public workers. By not taking immediate action, you create an atmosphere in which you can get away with almost anything. And don't they all know it."

NAEMT is fighting for YOU!

As an EMS professional, don't you wish you had a national presence in Washington, D.C., someone fighting for your interests? Someone with an understanding of EMS needs, who will stand up for practitioners' safety and advocate for better benefits and pay?

You do! The National Association of Emergency Medical Technicians (NAEMT) is YOUR advocate. Formed in 1975 and today more than 30,000 members strong, NAEMT is the nation's only association representing the professional interests of all EMS practitioners, including paramedics, emergency medical technicians, first responders and other professionals working in pre-hospital emergency medicine.

A key part of NAEMT's mission is to advocate in Washington on behalf of EMS practitioners. Here are a few ways we do that.

Position statements — NAEMT issues positions on issues of importance to EMS. These statements are widely distributed within the EMS and medical communities and federal agencies. Recent positions include EMS in Health Care Reform, EMS Practitioner Safety, EMS Patient Safety and EMS Ambulance Safety. You can view the full position statements in the Advocacy section of www.naemt.org.

Grassroots campaigns - We periodically conduct grassroots campaigns to advocate on issues of interest to EMS and invite our members to participate. Right now, we are lobbying to extend the Public Safety Officer Benefit program to ALL EMS workers, as it currently only covers government personnel. You easily can help advocate on this issue and make sure all EMS is represented by sending a letter to your congressional representatives, who currently are considering two bills. Simply view the What's New at NAEMT section on our home page to see how to get involved.

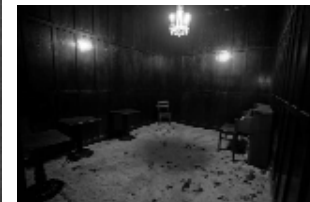
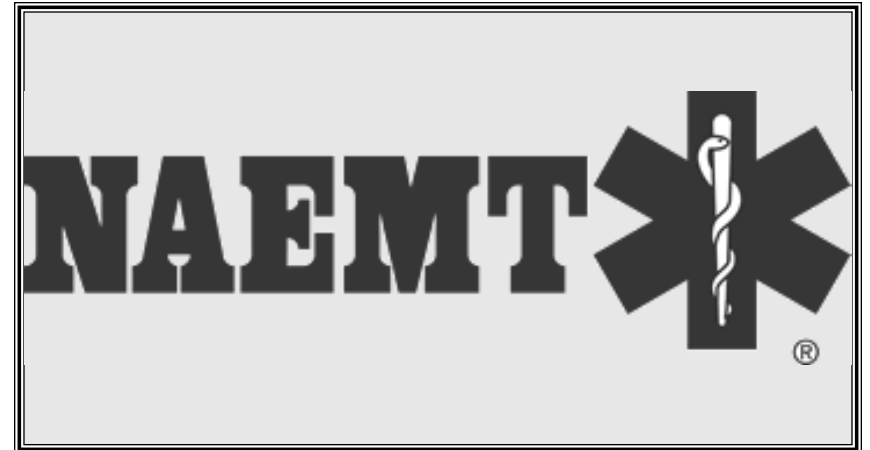
1st EMS on the Hill Day — This new event in May 2010 will bring

EMS leaders to the Capitol to advocate for EMS. It will be the first coordinated effort of its kind. Our annual EMS on the Hill Day event will include representation from organizations in all sectors of the EMS community; provide a consistent message to Congress on the key issues affecting EMS and practitioners; and encourage and promote participation by EMS practitioners from across the nation. Watch the web site for more details!

Your membership in NAEMT can help in these efforts. The more members we have, the stronger our national voice.

Plus, when you join, you receive thousands of dollars in benefits that far surpass the cost of membership, including members-only rates on health insurance, \$10,000 in AD&D insurance, discounts off EMS events, books, supplies and courses... and much more!

To learn more about NAEMT and how to join our advocacy efforts,



Tel. 718.383.2724,
Hours of operation:
5pm-2am, Seven days a week.
EMT-Paramedic Friendly.
www.dutchkillsbar.com



please visit www.naemt.org.

THE STREETS OF BROOKLYN

An EMS Anthem

Written by EMT Walter Adler and Hugh McEvoy sung by Vanessa 'Birdy' Rainwater in husky jazz vocals (with Irish twang)

The Service is a calling,
Ta Keep the Reaper at his bay,
And to keep our colors flying through dusk,
midnight and day.
O' the best years of our life,
We have bartered to this town.
Had I to guess, my EMS shall never let the City
down.

CALL US FOR THE STABBINGS, CALL US FOR
THE HEART ACHE
RED AND WHITE FLYS BY ON THE RUN;
Ta resuscitate departed and to get the heart rate
started,
But for the bullshit please call the 3-1-1!

Chorus:

O, ye'll take the defib and I'll take the stair chair,
An' if ya can stand; yer walkin'.
You'll hear our sirens wailin' in the middle of the
night

AS WE ROLL THROUGH THE STREETS OF
BROOKLYN.

O me brothers and me sisters,
Dear and true in heart,
Stand united in our cities life protection.
NOT A FIRE FIGHTER, OR A LAW MAN BY
OUR TRADE
How graceful' we accepted our dejection.

BUT ITS WE WHO DRAG FALLEN
FROM WHERE DYING THEY DO LAY,
It is life we prolong together.
With our golden hour, quick touch and aided
breath,
Unbreakable by will and weather.

Chorus:

O, ye'll take the defib and I'll take the stair chair,

An' if ya can stand; you're walkin'.

You'll hear our sirens wailin' in the middle of the
night

AS WE ROLL THROUGH THE STREETS OF
BROOKLYN.

As dauntless in our battle as tender in our love,
We'd yield ne'er an inch to the reaper-grim.
But never again ta leave fields o the' dying or the
slain
NO MEDIC or EMT before thim'.

O whither away, me liver and me pay,
THIS AMBA'LANCE MAN KEEPS ROLLIN',
The coming of the day, on the beach pensioned
away,
The swagger of me saves never stolen.

Chorus:

O, ye'll take the defib and I'll take the stair chair,
An' if ya can stand; yer walkin'.
You'll hear our sirens howlin' in the middle of
the night
AS WE ROLL THROUGH THE STREETS OF
BROOKLYN.

Can't we all just get along?

by Jon Saltzman, FDNY Sta 35

New York City Emergency Medical Services shows its face in many different lights. This city is unique. There are four distinct components to the pre-hospital response system. Municipal, Voluntary, Commercial and Volunteer. All of which ultimately serve the same purpose. We ALL do the same thing, treat, stabilize and expeditiously transport to definitive care. The contention amongst EMS between these four renditions of service seems to always come back to "who does it better?" The comparisons and contention is between apples and oranges. We all essentially do the same job just a little differently. This is the largest source of infighting and discord in our profession. This is nonsense. Most members of a profession will grasp for ways to justify their job as more important or better performed than someone else who does the same thing.

Who's to say municipal is better than voluntary? Who's to say that commercial can't cut it if it's anything but an inter-facility transfer? Who's to say that volunteers are incompetent? Ignorant people say, that's who. For every stereotype there are numerous contradictions, and yes, even some truths. Let's take a closer look at the differences.

Municipal (AKA the FDNY)

What they do: Ultimately responsible for the response to, and care of, any resident or visitor of the city of New York who requests or requires emergency medical assistance.

Pros: As an employee, there are primarily two features of working in the municipal sector that trump all. Healthcare and a pension. (and FDNY EMS is still getting the short end of the stick) Being a civil service employee has its perks. Let's not forget the pride of wearing that cool little patch and claiming to be a part of the biggest and best EMS system in this hemisphere. There's the job experience. Doesn't get bigger or badder than NYC right? There's also the substantial training.

Cons: The first and foremost is that the pay is atrocious. Scheduling work hours has almost no option for adjustment. It's very hard to stand out and excel through the ranks. Individual achievement is not rewarded. Employees are treated as just a number.

Myths: Everyone who wears an FDNY patch is the cream of the crop. The FDNY is the most progressive agency.

Truths: The FDNY is a very paramilitary organization. Employees are treated like army grunts. You won't find a more thorough and inten-

sive hiring/academy. There is no doubt that all new employees are wholly prepared as the FDNY sees fit. As an agency, the FDNY is respected in the EMS community worldwide.

Attitude: "We're the best so we run the show here."

Voluntary

What they do: Boiled down, voluntary agencies are simply supplements to the municipal system. They do the same job as municipal crews with the same responsibilities.

Pros: First and foremost the pay is substantially higher. It's much easier to become employed. Many of hospitals tend to take special care of their sick or injured employees.

Cons: There is an obvious disparity and lack of standardized equipment between agencies. There is a lack of standardized continuing education among agencies. FDNY has minor supervisory responsibility and agencies struggle to fill the field supervisory gap. Some agencies are non-union. There is lesser job security. Many agencies require employees to buy their own uniforms and equipment.

Myths: Voluntary providers are EMS members not good enough for the FDNY. Voluntaries are loose cannons and don't think they have to follow the rules.

Truths: Some of the best and most well trained providers work voluntary agencies. Let's not forget that many municipal employees moonlight at voluntary agencies. Not restricted to a tax base, many voluntaries have quite progressive and much better equipment than municipal tools of the trade.

Attitude: "I do the same job you do but get paid a hell of a lot more to do it so who's laughing now?"

Commercial

What they do: They are a business in the service industry. Businesses make money. Just so happens that the employees want to save lives while the bosses are concerned about billing and cutting costs. They provide the much needed service of emergent, non-emergent, and specialized medical transportation.

Pros: Many commercial agencies provide specialty services. NICU, bariatric, dialysis, cardiac cath, NYC Board of Ed and other types of transports. This makes for great street experience. There is often a better chance for advancement. More often than not work schedules cater better to real lives. Most commercial providers have a better working relationship with definitive care providers and have a better understanding of the continuum of care.

Cons: There is not much street emergency work. Let's face it, a transport unit will never scrape up a GSW in the hood. Business is business and job security is fleeting at best. Benefits packages are shotty at best. In regards to training, continuing education and general compliance with local medical standards, commercial agency compliance is anything but standardized.

Myths: Commercial transport providers are clueless to real emergency work. They really just specialize in a different kind of emergency work. Is a cardiac cath transfer any less dire than an in home MI?

Truths: Commercial EMS is a fantastic learning experience for anyone who wants to know more about medicine. They get to see the aftermath of what 911 providers don't see. They learn through reverse engineering sickness. As a more customer service driven business, commercial providers exhibit a better bedside manner and have more knowledge of long term healthcare, facilities, medications and disease processes.

Attitude: "We see and treat things you'll never see and have specialty training."

Volunteer (for the sake of not repeating ourselves, any reference to Hatzalah please refer to Issue 1)

What they do: These are local not-for-profit agencies that desire to provide an added service to their community.

Pros: This is a great learning experience for the general public who just want to give a little something back to their communities.

Cons: No pay and less experience due to lower call volume.

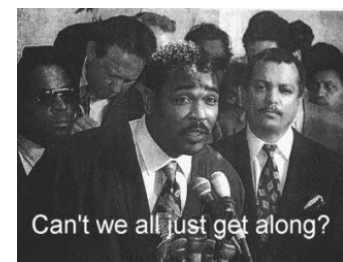
Myths: They can't be trusted to be competent providers.

Truths: Always eager, usually buffs, and trained just the same.

Attitude: "I have a real job but still have the integrity to give back to my community on my free time."

The bottom line is that regardless of the capacity in which we do our jobs, all EMS providers want, need, and deserve their fair share of the respect pie.

As a preface, and to establish some basis for this evaluation, be aware that in my 10 plus years in EMS I have worked in all four of these renditions, been BLS and ALS, a union shop steward and a supervisor.



Legaleeze: Regarding Emotionally Disturbed Patients.

We all interact with EDP's at some time or another. Not many of us know where our boundaries are in regards to physical and chemical restraints, forced transport compliance, medical safety, and our legal safety. Take a few minutes and read through the following documents. The first is a section of NYS law that we all have invoked at some point but may not have realized it. REMAC Protocols 430 and 530 follow and for all city 911 providers, FDNY OGP sections 106-03 and 106-08.

NYS Mental Health and Hygiene Law – Title B – Article 9 – Section 41

* § 9.41 Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers.

Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, or, pending his or her examination or admission to any such hospital or program, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action. * NB Effective until July 1, 2012

* § 9.41 Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers.

Any peace officer, when acting pursuant to his special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. Such officer may direct the removal of such person or remove him to any hospital specified in subdivision (a) of section 9.39 or, pending his examination or admission to any such hospital, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action. * NB Effective July 1, 2012

REMAC BASIC EMT PROTOCOLS

430 EMOTIONALLY DISTURBED PATIENT

NOTE:EMOTIONALLY DISTURBED PATIENTS MUST BE PRESUMED TO HAVE AN UNDERLYING MEDICAL OR TRAUMATIC CONDITION CAUSING AN ALTERED MENTAL STATUS. ASSESS SUCH PATIENTS FOR AN UNDERLYING MEDICAL OR TRAUMATIC CONDITION CAUSING AN ALTERED MENTAL STATUS AND TREAT AS NECESSARY.

1. Assess the situation for potential or actual danger and establish a safe zone, if necessary.

NOTE:ALL SUICIDAL OR VIOLENT THREATS OR GESTURES MUST BE TAKEN SERIOUSLY. THESE PATIENTS SHOULD BE IN POLICE CUSTODY IF THEY POSE A DANGER TO THEMSELVES AND/OR OTHERS.

2. If an underlying medical or traumatic condition causing an altered mental status is not apparent; the patient is fully conscious, alert, and able to communicate; and an emotional disturbance is suspected, proceed as follows:

- Request police assistance, if appropriate.
- Open communications with the patient.
- Attempt to determine the cause of the immediate crisis.
- Attempt to obtain a past medical history.
- Document the exact nature of the problem, including the patient's own words.
- If, in the judgment of the EMT/AEMT, the patient requires and is refusing treatment and the patient's judgment may be impaired, contact Medical Control.
- The EMT/AEMT may participate in restraining a patient if a police officer requests assistance or when it becomes necessary for self-protection.

NOTE:ONLY THE AMOUNT OF FORCE REQUIRED TO EFFECTIVELY RESTRAIN THE PATIENT MAY BE USED.

3. If the patient continues to struggle while being physically restrained, request ALS for possible chemical restraint.

4. Transport. 5. Assess and monitor Glasgow Coma score. (See Appendix E.) - Do NOT delay transport. Page C. 28 REMAC of New York City Prehospital Treatment Protocols (BLS Version 070109a)

REMAC AEMT (PARAMEDIC) PROTOCOLS

530 EMOTIONALLY DISTURBED PATIENT

1. Begin Basic Life Support procedures.

NOTE: ASSESS SUCH PATIENTS FOR AN UNDERLYING MEDICAL OR TRAUMATIC CONDITION CAUSING AN ALTERED MENTAL STATUS AND TREAT AS NECESSARY.

2. Contact medical control if patient agitation inhibits treatment.

3. POST IM or IN SEDATION: Begin an IV/Saline Lock infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock.

4. Begin cardiac monitoring, record and evaluate EKG rhythm.

5. Apply pulse-oximeter.

NOTE: IN ORDER TO PROTECT PATIENT'S AIRWAY, CONSIDER PLACING PATIENT IN A LATERAL RECUMBENT POSITION.

6. If patient is at risk for respiratory or cardiac arrest by continuing to struggle while being physically restrained by the police, contact medical control for implementation of one of the following MEDICAL CONTROL

OPTIONS:

MEDICAL CONTROL OPTIONS:

Prehospital Chemical Restraint Procedure

NOTE:IF PATIENT IS AGITATED, THE INITIAL ROUTE OF CHOICE IS IM OR IN. ONCE THE PATIENT IS SEDATED, IV ACCESS SHOULD BE ESTABLISHED IN THE EVENT ADDITIONAL SEDATION IS NECESSARY.

OPTION A: Administer Diazepam, 5 – 10 mg, IV/Saline Lock bolus. OR Administer Midazolam, 1 – 2 mg, IV/Saline Lock bolus or if IV access is unavailable, administer Midazolam, 10 mg IM or IN. OR Administer Lorazepam, 2 – 4 mg, IV/Saline Lock bolus or if IV access is unavailable, administer Lorazepam, 4 mg IM or IN.

OPTION B: Transportation Decision.

Page D. 33 REMAC of New York City Prehospital Treatment Protocols (ALS Version 070109a)

FDNY OGP 106-03, Addendum 1 2/10/05

RESTRAINT ASPHYXIA

1. PURPOSE

1.1 To set forth policy and procedures to improve patient safety when restraints are used, and to outline the medical concerns and dangers of "restraint asphyxia" in restrained patients.

2. SCOPE

2.1 This procedure applies to all members of the EMS Command and to Voluntary Hospital personnel who provide pre-hospital emergency medical care in the New York City 911 system.

3. INTRODUCTION

3.1 Restraints are often necessary to prevent patients from harming themselves or others. Failure to use restraints could result in injury to the provider, the patient or others. Anticipating the need for restraints before it becomes necessary improves patient safety and may eliminate the need for their use. However, there are inherent dangers to patients when restraints are used and the patient is not properly positioned.

3.2 This directive does not replace or supersede Department training and policy regarding when or how to restrain a patient.

4. DEFINITIONS

4.1 Positional Asphyxia – any body position, which restricts or interferes with an individual's ability to breathe.

4.2 Restraint Asphyxia – a form of positional asphyxia that occurs during the process of subduing and restraining an individual, compromising the individual's ability to breathe, and often resulting in death.

4.3 Agitated or Excited Delirium – an acute confusional state associated with irrational behaviors including violent, aggressive, and/or paranoid features.

4.4 Verbal De-escalation – communication techniques used to defuse stress and anxiety and avoid physical confrontation.

5. RESTRAINT-RELATED COMPLICATIONS

5.1 Life-threatening complications and death have occurred to restrained individuals in police custody and in health care settings. Recent studies have described a number of factors contributing to the death of a patient in restraints. Restraint asphyxia is used to describe a type of traumatic asphyxia that occurs because of the patient's

body position during restraint, especially when in the prone position (positional asphyxia). Factors that contribute to such asphyxia may include:

5.1.1 Obesity.

5.1.2 Prolonged physical exertion (i.e. flight from custody, struggling against restraints, seizure activity).

5.1.3 Agitated delirium.

5.1.4 Use or history of use of stimulants, in particular cocaine and methamphetamines.

5.1.5 Pre-existing cardiovascular disease, especially hypertrophic cardiomyopathy (enlarged heart).

5.1.6 Exposure to mace or pepper spray.

5.2 Studies have shown that restraint asphyxia causes life-threatening complications and/or death. The mechanism of death begins with the patient's own weight interfering with effective respirations, producing hypoxia and severe acidosis. The process starts when weight is applied to an individual who is usually in the prone position, while being controlled or restrained, or his/her own weight (or abdomen) compresses the chest cavity. This is followed by progressive fatigue of the accessory muscles of respiration. The patient's natural response to increasing difficulty in breathing is to struggle more violently, which may be met with still more restraining force, resulting in greater oxygen deficiency and, in some cases, rapid death.

5.3 Exhaustion and muscle fatigue contribute to respiratory failure. Restraining a patient, specifically one who is prone, poses further mechanical challenges to already over-taxed respiratory muscles. Struggling during the restraint process, and while restrained, can produce extreme exhaustion and metabolic acidosis, exacerbating many underlying medical conditions.

5.4 Agitated delirium, sometimes referred to as excited delirium, has been linked to sudden death in restrained patients. It is known to produce an acute onset of bizarre and violent behavior, and may be accompanied by combativeness, hyperactivity, unexpected "superhuman" strength, paranoid delusions, incoherent shouting, hallucinations, and hyperthermia. Underlying causes of agitated delirium include postictal states, manic-depressive psychosis, chronic schizophrenia, poisoning, cocaine intoxication, alcohol or amphetamine withdrawal, and head trauma. Agitated delirium, combined with the additional exertion of struggling while being restrained, and against the restraints, places stress on the heart (fight or flight response), and increased oxygen demands on the heart and lungs, leading to sudden death. Addressing the underlying cause of the altered mental status may eliminate the need for continued restraint.

6. POLICY

6.1 Prehospital care providers should provide humane, professional, and appropriate emergency care to all persons, regardless of their emotional or behavioral state. This applies to all patients, including those under arrest, in police custody, or institutionalized.

6.2 Members must make every effort to assure an open airway and unrestricted chest movement when treating a restrained patient. Continuous patient assessment and airway and respiratory monitoring is critical. Anticipate the need for suctioning and have it ready.

6.3 At no time is a restrained patient to be transported in the prone position, or in any position that compresses the chest. If a patient is restrained, with hands behind the

back (including by handcuffs), the patient should be transported preferably left lateral recumbent or upright semi-fowlers.

6.4 If the patient continues to struggle against restraint, members should make every effort to provide oxygen to the patient via non-rebreather mask. Request ALS assistance and a Conditions Supervisor. Do not delay transport to await ALS or the Supervisor.

6.5 Members need to be cognizant of alternatives to restraint. Use of a restraint in many instances is not the best method for controlling patient behavior. Consider adjusting the environment by reducing noise and bright lights. Help the agitated patient focus by engaging him in conversation. A calm, respectful and confident rapport has a deescalating effect. Effective use of communication skills will reduce injuries to providers and patients.

EMSC OGP 106-08 DATE: JUNE 15, 1999 **ASSIGNMENTS INVOLVING AN EDP**

1. PURPOSE

1.1 To establish guidelines to ensure the safety of patients and members of the EMS Command, when encountering an emotionally disturbed patient (EDP) and to define responsibilities prior to the arrival of and during the presence of police officers.

2. SCOPE

2.1 This procedure applies to all members of the FDNY EMS Command and to employees of voluntary hospitals who provide pre-hospital emergency care through the New York City 911 system.

3. POLICY

3.1 The Police Department is charged with the responsibility of custody, restraint, and resolution at incidents involving emotionally disturbed patients (EDPs). Fire Department EMS Command or Voluntary Hospital units often respond to incidents involving individuals who are threatening physical harm to themselves or others. No attempt shall be made by members of responding EMS units to restrain an emotionally disturbed patient who is violent, unless they are requested to assist a police officer in doing so.

4. PROCEDURE

4.1 Upon arrival at the scene of an assignment for an emotionally disturbed person, members shall:

4.1.1 If a patient is found to be emotionally disturbed, but is not violent and does not have a history of violent tendencies, evaluate and treat the patient prior to the arrival of a police officer.

4.1.2 If the patient is willing to be transported to a hospital and, in the members' judgment, the patient can be removed without restraint or police assistance, remove the patient to the appropriate ambulance destination without awaiting the arrival of a police officer.

4.1.3 If the patient does not desire transportation to a hospital:

A. Contact On-Line Medical Control for guidance in determining the patient's ability to knowingly decline treatment and/or transport.

B. If necessary, request police assistance.

C. In any event, make every effort to avoid agitating the patient while a transportation decision is being made.

D. If a patient is found to be emotionally disturbed, and capable of violent action:

1. Await the arrival of the police before entering the premises or attempting to treat the patient.

2. Not knowingly approach or remove a violent emotionally disturbed patient without police assistance and/or without a police officer accompanying the patient.

3. If no police officer is present, request that a second call for police assistance be made.

4. If police officers have not arrived after 15 minutes on the scene, advise the dispatcher of same and await direction.

4.1.4 If an emotionally disturbed patient is holding someone against their will, notify the dispatcher and request the response of the police and a Conditions Officer forthwith.

4.1.5 If the police at the scene find it necessary to utilize restraining equipment, such as handcuffs:

A. Ensure that the patient is positioned in such a way that will facilitate CPR, should it become necessary. At no time is a restrained patient to be transported in a prone position.

B. Ensure that at least one police officer accompanies the patient in the back of the ambulance. A police officer must ride in the body of the ambulance when a patient is restrained, as per NYPD Patrol Guide Procedure.

4.1.6 All emotionally disturbed patients shall be transported to the closest appropriate 911 receiving hospital even if its catchment area does not include the location from which the patient was transported.

NOTE: As with all medical emergencies, upon arrival at the hospital, psychiatric patients will be evaluated by a physician, who will determine if the patient should be admitted for further evaluation and treatment. If the physician later feels that the patient requires transfer to a different facility (shortage of resources, need for special treatment, etc.) it is the receiving hospital's responsibility to arrange an inter-facility transfer, in accordance with REMAC Inter-Facility Transfer Protocol.

4.1.7 When an emotionally disturbed patient is to be transported in police custody from a police facility and no police officers are immediately available to accompany the patient, the members, after evaluating the patient, shall

A. Establish contact with the desk officer and request for assistance.

B. If no police escort can be provided within 15 minutes of this request, and the patient has no underlying medical or surgical problems requiring immediate care, inform the desk officer that they are unable to await the escort and that a unit will return when notification is made that an escorting officer is available.

C. Transmit a disposition reporting that the patient was treated but not transported, document their ACR accordingly, and return to an available status.

4.2 Conditions Officers, when requested to respond to an incident involving an EDP, shall:

4.2.1 Assist the unit in facilitating the transport of the patient.

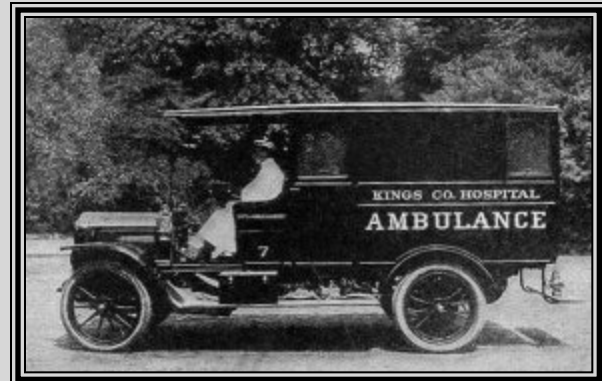
4.2.2 Ensure compliance with all appropriate FDNY policies and procedures.

All protocols and OGP's reprinted verbatim and current as of this printing.

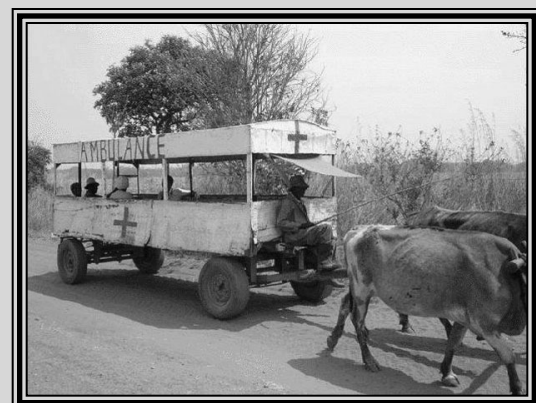
A progression of ambulances through the ages



Clockwise from top: (1) Civil War era ambulance c.1862, (2) Kings County Ambulance c.1910's, (3) 2009 FDNY Rescue Ambulance, (4) NYC HHC EMS Breadbox Ambulance c.1970. Photos 1,2,4 courtesy of Lt. Vincent Santioemma FDNY



ambulances from across the globe



The Fable of the Skell

Excuses

by EMT Thomas Ansu and EMT Walter Adler

Scenario 1: Why didn't you log on on time?

My partner was praying. We needed to change the main O2. The ambulance was misplaced. The last crew left it a bloody mess. There is still a patient in my ambulance. My ambulance smells like urine. I didn't remember my partners shield.

Scenario 2: Why weren't you at your 89.

My partner is a Jew; he needed to find kosher food. My partner is Muslim he needed to find Hillal food. We needed to get fuel. The scene of my 89 was becoming unsafe. I'm truly terrified of white people. The neighbors were complaining about the exhaust. My partner is an EDP. My partner is a skell. My partner is flatulent. My partner has gypsy like qualities.

Scenario 3: You are accused of an EEO violation.

My partner is an asshole. My partner attacked one of my 26 protected categories first. Some of my best friends are black. Some of my best friends are gay Muslim Eskimos. I was trying to create jobs for unskilled, untalented lawyers in a troubled economy. In my protected category what I said was a compliment. I was going to file an EEO a week ago but I wanted to be the bigger wo(man). In former Soviet Union horse can drive and woman cannot. I was molested as a child. White people sold my people into slavery. I'm a quarter Irish. I love Italian food.

Scenario 4: Why didn't you give the patient oxygen?

There was plenty of oxygen in the air of the room. The patient kept smoking cigarettes. They refused the O2, then refused to sign. The patients face was too fat for the NRB. The patients face is oddly shaped. The patient had gypsy like qualities. The regulator was broken. My patient ate the regulator. My patient claimed to be allergic to high concentration oxygen. My patient was a member of the living dead. My patient claimed that oxygen gives him gas. My patient claimed that Oxygen is a plot of the devilish white man.

Scenario 5: Why didn't you use the stair chair?

Because I don't want to let the terrorists win. Because it is an inherently un-safe and antiquated carrying device. We were on the first floor. I felt he needed to walk it off. Because I'd been to a Bar Mitzvah this week already. The pain was in his chest not his legs. He was walking around the apartment just fine. He said carry me slave.

Scenario 6: Why were you late to work?

Accident on the highway and I stopped to help. Fire trucks were obstructing the street. I was arrested for possessing an unlicensed fire arm. A fire man slashed the tires to my car. A fire man set my car on fire. I locked my keys in the car. I'm not allowed to drive until sun down. I was early yesterday. My husband doesn't allow me to operate a motor vehicle. Some gypsy jumped in front of the train. I have epilepsy. My dollar cab driver was arrested and deported. I was hit by a car. My bike tire popped. I have swine flu. I was kidnapped by the Latin Kings. I was stuck in the elevator of my building. I'm a member of a group of masked avengers.

Scenario 7: Why were you on scene for so long?

Obtaining complete list of medications. The patient was three times my size. My patient produced a chicken sandwich from under her arm and began to eat it. My patient was actively smoking the drugs. My patient refused to go and was highly intoxicated. I was locked out of ambulance. The fireman stole my ambulance. The fireman lit my ambulance on fire. I was awaiting firemen for a lift assist. Extremely complicated extrication. The firemen immobilized the patient prone. The fire man boarded a dead patient. My patient was living fifteen stories beneath the earth's surface. We didn't have the right address. My partner was playing hard to get. My partner was under the influence of my patient's daughter. Our patient insisted on cooking us platanos.

Scenario 8: How did you injure yourself?

My partner lost control of the terrorist like stair chair. The patient was bigger than the ambulance. My patients little brother assaulted me than ran off down the street. The firemen beat us and left us for dead. Because I love my city so much sometimes, I needlessly put myself in harm's way. I had thought the ambulance could clear 7'0". The gypsy cab swerved in front of us. I was ordered to work 12to 16 hours shifts for a year without vacation. I dislocated my shoulder do to the vigor and depth of my compressions. Because the good of the service is a detriment to my back. The previous crew had permanently disabled the seat belt.

Scenario 9: I'd like you both to write a statement.
YOU SAY: I'D LIKE TO EXERCISE MY WINE-GARTEN RIGHTS AND AWAIT THE ARRIVAL OF A UNION DELAGTE BEFORE ASKED TO INCRIMINATE MYSELF.

Your statement should not exceed two sentences.

Scenario 10: You crash the ambulance.

I was avoiding a driver coming the wrong way down the street. People drive like they still live in

Pakistan. I was avoiding an oncoming fire truck. The roads were wet. I have seizures. My partner has cerebral palsy. I had never driven before this job. My EVOC instructor may have been taking quelled. EVOC was only 9 days long. A child ran in front of us. There was a crackhead lying in the middle of the road. The road was icy. There was pot hole the size of the Grand Canyon. I suffer from narcolepsy.

Scenario 11: Why don't you want to become a medic?

I'm afraid of responsibility. Contracting AIDS or Hep C doesn't appeal to me. Because they don't get the good trauma jobs. Because EMT sounds more sexy to say. Because all my partners will have a higher reading level.

Scenario 12: Why don't you want to become a Lieutenant?

Because I don't believe in socialism. Because baby blue clashes with my eyes. Because I don't respect authority. Because I don't have the heart to take a man's pay from him when he works for peanuts and has to feed three children. I don't want to break a man's pride. Because there is a war going on between good and evil and I don't want to flop sides. I'd prefer to promote directly to captain. I'm not entirely sure I can pass the drug test this month. Because I already raise four children, I don't need a whole battalion more of them. Because I can't accessorize my uniform as much. Because I was popular in high school.

Scenario 13: Why not become a fireman?

I would like to be a fireman.

Or

Because flame never surrenders. Because my hair is highly flammable. I don't want to downgrade my level of training. Because the country I come from doesn't start with an I. I was in a fraternity already and I didn't get laid as often as they said I would.

The preceding was simply a lighthearted account of some of the funny, ridiculous and realistic excuses around. We declare that no EMT's were harmed in the making of this article.



Learn Patoi for EMS

by Dave Briscoe EMT-CC

- Looks like an exacerbation of Akee poisoning
Loke like da bumba klot akki sikneh.
- There's no way in hell I'm cutting Dreadlocks, Lieutenant.
Jah would neva give da powa to ah ball head.
- Officer please stand back, some EDPs are made more violent in the presence of the law.
Babylon fawl bak, maan sick head na good.
- Tell your white boy partner it's not a burrito, it's a Roti.
Tell dutty duppy man dweet, what sweet nanny goat a go run him belly.
- What kind of allergies do you have?
Yah sick wit allergy?
- Don't just stand there thinking I'm going to help you.
Tandy tink sey im a-go help you.

- What medications do you take?
What kinda ting dem docta gave ya?
- We don't carry medicinal marijuana in our tech bag.
We don' have no herb.
- I said Oxytocin not Oxycontin.
You mussy bleed pon ya rag.
- As soon as I get my money right I'm buying an enormous home back on the Island.
Afta me cook up, me akki an saltfish, me ago roastmee breadfruit.
- You can't bring all six girls to Kings County Hospital.
Dred, what kindoff armshouse ya take dis for???
- Your social security number needs three more digits.
Wah kinda fuckreh!, Numba dis?
- You cannot take an ambulance to Temptations night club.
A bash you wango, you tek man for fool!?

Submissions

To all readers, this paper is for *you* and we are working on making it 'by you' also. This is not supposed to be the voice of a few but a voice of us all. Exercise this opportunity to make your voices heard. That takes input and submissions. We encourage everyone and anyone to submit anything they think is printworthy. Articles, reviews, kudos, letters to the editor, good to know information, etc. It's very simple. Send any content (articles, photos) to emsbanshee@gmail.com. We also encourage all readers to join us on Facebook (group: *The EMS Banshee NYC EMS Publication*). Even if you don't feel comfortable submitting content, feedback on how we're doing is always welcome.

Distributors

As always, this effort could not be done without the direct support and help of our readers. We always need volunteers to help get the paper, and the word, out on the streets. If you would like to volunteer in any way, please contact us via email.

Advertising

We welcome requests for advertising from anyone. Please email us for more information.

Jo - Paul s

Uniforms * Police Equipment * EMS Supplies

105-02 Jamaica Ave. Richmond Hills, NY 11418
(718)849-3861

Open Monday thru Saturday till 7pm

REDIMEDICS SHIFT CALENDARS

PROTOCOL BOOKS

LITTMAN STETHOSCOPES

293 E 10 St.
@ Ave A
NYC

Middleeastern Cafe & Hoorah Lounge

www.horuscafe.com

HORUS CAFÉ



"I gave blood today."



STRAIGHT TO THE VAMPIRES

...and by "blood" I mean my civil service status, and by "vampires" I mean politicians who want to strip me of my working rights.

So I joined the Banshee Association...