

To the Editor:

In the article, "Paramedic Field Instructors: An Approach to Training the Newest Paramedics While Maintaining the Interest of the Most Successful Senior Paramedics," published in *Prehospital and Disaster Medicine*, April–June 1995, Krochmal et al have attempted to address two major problems all emergency medical services (EMS) systems face: 1) effective integration and supervision of the clinically inexperienced advanced life support provider; and 2) motivating the senior paramedic to remain enthusiastic and committed to competent (and compassionate) clinical-care delivery.

The paramedic field instructor program crafted by the New Haven EMS system may be unique because it has used a single approach to handling several different system management needs. The idea of taking senior, experienced paramedics and finding a way to motivate them to share their experiences with others is not a novel intent. However, their success may be. Under the system they describe, everyone wins—the paramedic, the student, the new intern, the senior paramedic, even the patient!

After reviewing the article, I was left with several questions. They include:

1. Was the selection criteria used to identify the 30 paramedic field instructors adequate in providing the system with the quality they desired? For example, was there a difference between those selected who had previous teaching experience compared to those without? The initial four-hour training period seems, on the surface, to be quite short to prepare the inexperienced instructor/preceptor adequately.
2. The idea of presenting challenging continuing medical education (CME) to the new as well as the "old" paramedic is a constant challenge. Was the monthly three-hour CME in which the paramedic field instructors participated in addition to or in lieu of the normal monthly session that they already were expected to attend? If it was in lieu of that normally required, were there any problems encountered with meeting national registry and/or state recertification requirements, given that it appears that many of the items discussed were not necessarily of a purely clinical nature?
3. There is little reason to doubt that the presence of the motivated group of paramedic field instructors can lead to improvements in training and field performance. However, what objective data were found to validate the "real" benefit of the new program? In turn, can these data now be used to justify these individuals receiving a higher salary for their work?

This paper also describes the instructional and the evaluational role played by the paramedic field instructor. However, it failed to describe the system criteria used to assure performance quality among the paramedic field-instructors. Did each paramedic field instructor become responsible for only one student or intern, or several? For the system to receive an ultimate benefit from a paramedic field-instructor program, each perfor-

mance must be of a similar qualitative nature. Was there satisfactory inter-reliability found among the 30 personnel? If not, what were the problems that were seen?

In summary, the paper presents one suburban area's attempt to implement an innovative idea to meet several needs. Their experience would seem to verify what many systems have known for some time. Some of our best instructors are not found just in the classroom. Despite the important information shared by their report, there are a number of other questions that must be answered before the full impact of a program like this can best be understood and emulated.

Craig DeAtley, PA-C
George Washington University
Washington, D.C. USA

To the Editor:

Schmidt et al reported the successful resuscitation of a child with severe hypothermia after cardiac arrest of 88 minutes in 1986 in the January–March 1995 issue of *Prehospital and Disaster Medicine*.¹ Although the patient was asystole at the time of admission to the emergency department, he was warmed by external warming and warmed inspiratory air during prolonged mechanical cardiopulmonary resuscitation. This 9-year-old report, which was first published in 1988, is still most remarkable with its very good outcome.²

Recommendations for the treatment of severe hypothermia have changed,³ and different management of severely hypothermic patients with cardiac arrest is used in our emergency department. We have treated 26 severely hypothermic patients with body core temperatures below 30° C in our emergency department since 1992. Four patients suffered circulatory arrest (one EMD, three patients ventricular fibrillation). One patient (28.7° C) stabilized after defibrillation and was warmed by warmed infusion, warmed inspiratory air, and bair hugger. Three patients (23.9 to 24.6° C) were warmed by cardiopulmonary bypass (CPB) (Biomedicus, Medtronic pump with a heparin-coated system). Percutaneous vascular femoral-femoral cannulation required 17 minutes to 35 minutes. CPB-time was 90 minutes to 205 minutes. All four patients were long-term survivors without neurological deficit. The use of a mechanical chest compression system, "Thumper," facilitates prebypass management (i.e., the cannulation of vascular access), but cannot replace cardiopulmonary bypass.

Although successful reanimations of asystolic patients with accidental hypothermia by other methods have been reported, the best possibility to restore spontaneous circulation in asystolic hypothermic patients is active re-warming by CPB.^{4,5} Hospitals that have the possibility of treating hypothermic victims should possess the facilities for CPB, so that extracorporeal life support can be provided without delay in life-threatening circulatory failure in hypothermic patients.^{6,7}

M. Roggela, A. Wagner, W. Hoedl, A. Michalek, G. Roeggla
Department of Emergency Medicine, University of Vienna