THE ALABAMA OFFICE OF EMERGENCY MEDICAL SERVICES






EMS QUARTERLY NEWSLETTER

From Mobile to Huntsville and Everywhere In-Between

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STROKE & TRAUMA SYSTEM SITE VISITS.

William Elwin Crawford, MD, NRP, FACEP
EMS Medical Director, State of Alabama

The OEMS Acute Health System staff and ATCC leadership have been doing site visits to stroke and trauma hospitals over the last few months. We periodically do revisits to these hospitals, and it is always enjoyable seeing old friends and developing new relationships with folks at these hospitals.

Many of the folks in the hospitals got their start in EMS and speak the EMS language. It is always good to see these folks and the excitement they bring to the hospital side of the house.

One of the things that always strikes me is that different hospitals do things differently, but all have an end goal to take good care of patients. This is especially true with those patients of the stroke and trauma systems. This is true on the prehospital side as well. We all may wear different uniforms, but we all share the common goal of providing excellent care to our patients.

I say this to all of you in EMS that we at the OEMS are grateful for what you do and the compassion that you show to patients every day.

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Elwin Crawford, MD, NRP, FACEP

NOTES FROM THE DIRECTOR:
Provision of Professional Services
Jamie Gray, BS, AAS, NRP, TP-C
State EMS Director

Most people who are EMS field providers, or even Emergency Medical Provider Service operators, never consider the fact that, as EMS providers, we should be providing both excellent clinical care as well as excellent hospitality services.

The verb for hospitality is "host" and no better definition for that word exists than "to welcome or receive someone in a friendly way". The fact is that true professionalism is based not only on expertise in clinical assessment and provision of clinical treatment, but doing so in a way that will ensure the patient's confidence and cooperation with the assessment and treatment process. I invite you to consider the fact that nothing goes farther in winning a patient's confidence than calm, friendly, empathetic interaction with a knowledgeable EMS professional.

I have often written and spoken on the necessity of empathy when interacting with family and treating patients. That empathy does not have to stop within ourselves. If we are empathetic, we tend to take extra time to consider the patient's condition, treatment priorities, equipment application, or precautions. Empathy involves active listening, non-verbal cues, and verbal acknowledgement of the patient's feelings without judgement. Active listening is an imperative skill of patient care.

Active listening is the best device to completely derive information from a patient. It involves paying full attention, undivided and without interruption, to the patient's statements as well as their physical signs and symptoms. Our education, training, and experience help us to understand what we see and hear. For example, obvious labored breathing correlated with rales when auscultating the lung fields. Our education, training, and experience also lead us to provide associated evaluation techniques (such as pulse oximetry) and treatment processes (such as oxygen, CPAP, and albuterol if needed).

In the reality of active listening, we should also consider the use of non-verbal cues such as open posture which demonstrates interest, appropriate facial expressions and eye contact that demonstrates that we are present and engaged. Verbal cues such as small affirmations while listening, such as nodding while saying "I see" or better "yes sir or ma'am" or "no sir or ma'am" to demonstrate we are following along in the conversation as well as showing respect for the individual. When returning to the interview process, we would then follow with open-ended questions, which is likely the first part of this process that we received training on.

It is important to remember that during this process the patient and/or patient's family may be completely terrified. Empathetic attitude goes a long way in winning confidence but actively (and honestly) demonstrating our empathy may be a much greater tool in our patient care repertoire. It is the honest and physical demonstration of empathy that crosses into the realm of "hospitality" for lack

of a better term. I have to anticipate that some EMS professionals are not comfortable with the concept of providing hospitality for their patients.

American society seems to immediately associate "hospitality" with other industries which is not untrue, but we must take into account the meaning behind the term. The U.S. Department of Labor classifies hotels, restaurants, theme parks, bars, and tourism under the broad term "hospitality industry." And most would stand firm on the statement that our role in society is to save people's lives, not to coddle them.

In comparison of the hospital industry and the hospitality industry, much is shared in addition to the root word *host*. Both industries require customer recognition, loyalty, and confidence. Both industries share a customer-centric approach to the services they render. They both rely upon customer feedback to maintain quality improvement, howbeit with hospitals also heavily considering healthcare outcomes. Long ago hospitals recognized that positive healthcare outcomes are correlated to patients feeling better, which is correlated with how they are treated as people. Both industries directly affect their customers emotional state while striving to positively promote confidence in the system.

It may be true that restaurants, bars, theme parks, hotels, motels and tourism actively seek to win the trust and loyalty of customers to encourage future patronage, however it is also true that hospitals do the same thing. The hospital industry is highly competitive. Patients will travel considerable distances to be treated and admitted in hospitals that have better reputations, known for "better" services, friendlier practitioners, and other features. This is amplified by the fact that the reputation of most service industries, including EMS, are more heavily negatively affected by a single mistake or event. Any industry learns from mistakes that are recognized and corrected but medical industries lose great amounts of positive reputation based upon public perception, especially in the digital age where there may not be any accountability for statements rendered.

Hospital clients, as they are referred, are provided services based upon the recommendation of medical providers (physicians) and applied by expert personnel (nurses, respiratory therapists, technicians, etc.). The same is true in prehospital EMS if you think about it. We follow protocols authored by physicians and provide care under the auspice of online and offline medical directors who are physicians. So the major difference is that we often consider our patients (clients) as sheep under our supervision and protection as shepherds. The fact that we often do not consider is that shepherds lead by example, by gentle guidance based upon confidence and security that the sheep feel in the shepherd's presence and by direction with gentle nudges rather than force.

I encourage all EMS personnel to develop a client-based treatment style based upon friendly, supportive and pleasant guidance and interaction. Not only will that approach encourage confidence, thus cooperation and satisfaction, but it will also improve the overall outcome of the patient based upon positivity applied during a particularly unpleasant time in the patient's life. We should strive to make EMS in Alabama the best representative of the old adage of "Southern Hospitality".

ALABAMA STROKE SYSTEM UPDATE

Tabatha Ross, BSN, RN
Acute Health Systems – Stroke System Coordinator

Committed to advancing stroke and cardiovascular care across Alabama

The Alabama Stroke System continues to make great strides in improving access to timely, high-quality stroke care throughout the state.

New Facility in Region 4

In August, a Level III Stroke Center site visit was conducted at Vaughan Regional Medical Center in Selma, AL. The facility was approved for entry into the system by the Statewide Trauma and Health System Advisory Council (STHSAC) on September 17, becoming the third new facility in Region 4 to join the system this year.

Level III hospitals play a vital role in the system, caring for patients with mild stroke symptoms and stabilizing those diagnosed with stroke before transfer when needed. Alabama currently has 87 hospitals in the Stroke System: There are 8 level I, 5 level IIa, 23 Level II and 51 level III, making Level III centers the backbone of stroke care in the state.

Out-of-State Partner Renewals

We also renewed designations for our valued out-of-state partners, whose collaboration ensures that Alabama patients have access to the full continuum of stroke care when system facilities are unavailable.

Sacred Heart Hospital – Level I Comprehensive Stroke Center (renewed August 5)

Baptist Health Pensacola – Level IIa Thrombectomy-Capable Stroke Center (renewed August 19)

These hospitals are equipped to deliver all levels of stroke care and play a vital role in managing our most severe cases.

Coming Soon: Alabama Statewide STEMI System

We are excited to share that we are in the planning stages of developing a Statewide STEMI System. This coordinated system will focus on reducing heart disease–related mortality and morbidity by improving the rapid identification, treatment, and transfer of heart attack patients.

Heart disease remains the leading cause of death in Alabama, and this initiative represents a major step toward improving outcomes and saving lives across our state.

The STEMI System will work hand-in-hand with the Alabama Stroke System to strengthen emergency cardiovascular care, ensuring patients receive the right care at the right place at the right time. Through continued collaboration with hospitals, EMS agencies, and state partners, we are building a stronger, more connected network to serve the people of Alabama.

Together, these efforts reflect our unwavering commitment to expanding access, improving outcomes, and advancing the standard of care for both stroke and heart disease throughout Alabama.

URBAN SEARCH AND RESCUE (USAR)

ALABAMA Emergency Medical Services

SPOTLIGHT ON EMS

In the previous newsletter, Dr. Crawford mentioned seeing the Urban Search and Rescue Task Force from the Tuscaloosa area in action while he visited central Texas in July. That Task Force, and others, were assisting public safety groups there in managing rescue operations in the July 2025 floods. Alabama sent two groups comprised of personnel from nine Alabama fire departments, the groups totaling more than fifty individuals. Both groups spend approximately two weeks on site in devastation, searching for injured patients, rescuing injured and displaced persons, and searching for the bodies of those succumbing to environmental extremes. Director Jamie Gray then wrote a special thanks to those volunteering to undertake the herculean task of weathering the same environmental extremes for multiple weeks to assist services and citizens in another state. We take this opportunity to briefly highlight the existence of such Task Forces locally, nationally, and abroad.

Urban Search and Rescue (USAR) task force teams are found throughout the United States and the world. The task forces are comprised of firefighting, law enforcement, emergency medical services, public health, and other needed specialties. The purpose of a task force is to respond to local or mutual aid areas to intervene in widespread public safety overload secondary to natural (storm, earthquake, etc.) industrial (mine collapse, trench collapse, etc.) or purposeful (results of the acts of terrorism) multiple casualty situations. The general goal of the process is access and rescue regardless of environment or terrain and including water rescue.

The United States system is operated under the Federal Emergency Management Agency (FEMA). According to the FEMA website, the National Urban Search & Rescue (US&R) Response System (the System), established under the authority of the Federal Emergency Management Agency in 1989, is a framework for organizing federal, state and local partner emergency response teams as integrated federal disaster response task forces. The System's 28 US&R task forces can be deployed by FEMA to a disaster area to aid in structural collapse rescue, or they may be pre-positioned when a major disaster threatens a community.

Internationally, the United Nations (UN) under the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) developed the International Search and Rescue Advisory Group (INSARAG) and established the group in 1991. According to the UN website, this establishment followed the initiatives of the specialized international Urban Search and Rescue (USAR) teams who operated together in the Mexican earthquake of 1985 and the Armenian earthquake of 1988. So as not to duplicate existing structures, the group was created within the framework of existing humanitarian coordination within the United Nations (UN). To this end, the group's secretariat falls within the Emergency Response Section (ERS) of the Response Support Branch (RSB) of the Office for the Coordination of Humanitarian Affairs (OCHA) in Geneva.

In Alabama, major fire departments participate in the initiation, manning and maintenance of the System throughout the state. The first, and largest, USAR Task Force, AL-TF1, was formed and initiated by the Mobile Fire Department in 2002. Sherry Crush, retired Mobile Fire Rescue Department

captain and former head of their USAR, advised that funds made available through FEMA just prior to September 11, 2001, made the Alabama Mutual Aid System (AMAS) possible and initiated the development of Mobile's Task Force 1 which came completely to fruition in 2002. Captain Crush went on to advise that Mobile Fire Rescue Department's Chief Doug Cooper (now also retired) was likely the person most responsible for the development and initiation of Task Force 1, which mirrored teams in Florida and California that had developed in the 1990's. She also advised that Task Force 1 was the first Alabama team to be accredited by EMAP, the Emergency Management Accreditation Program, and remains the only Type 1 Task Force in Alabama as well as the only Task Force comprised from only one Fire Department. By definition, a Type 1 team is a fully equipped, multi-disciplinary, and highly specialized force designed for the most complex and demanding urban search and rescue missions. They are capable of sustained, independent operations and often serve to support Type 2-4 teams, which are designed to quickly move into areas requiring a mission-specific operation and are generally initial response teams.

Mobile Fire Rescue Captain Howard Popple, the current Program Coordinator for Alabama Task Force 1, explained that the approach used in USAR is basically cataloging for standardization (resource typing) for coordinated team utilization during natural and manmade disasters. He gave the example of wildland firefighting as an endeavor that is rural by nature, which is generally low population and isolated, but requires considerable team strength in numbers to limit damage and extinguish as efficiently and effectively as possible. Captain Popple, who is also a board member and treasurer of the State Urban Search & Rescue Alliance, described the Alabama Mutual Aid System as being broken up into seven divisions, identified as Divisions A through G. Each Division is manned by firefighters and rescuers within the Division's region. Each Division varies in number and types of teams available within the contingent departments. Captain Popple explained that some Divisions have more teams and varied types of teams available due to the area population, thus presence of fire services. He also advised that in addition to the different team types available in each Division throughout the state, the Incident Management Team is located within the Alabama Fire College in Tuscaloosa, located in Division C.

Whereas a complete description of Alabama team distribution and typing are beyond the scope of this article, maps and team descriptions can be found at the Alabama Emergency Management Agency (Alabama EMA) website on the Alabama Mutual Aid System subpage. Link below:

https://ema.alabama.gov/alabama-mutual-aid-system/

Additional information on the Federal components and national distribution of Urban Search & Rescue teams are available on the National Urban Search & Rescue Response System website as well as the Federal Emergency Management Agency website. Links below:

https://www.responsesystem.org/

https://www.fema.gov/emergency-managers/national-preparedness/frameworks/urban-search-rescue

The Alabama Office of EMS wishes to recognize and thanks each one of the constituent departments, agencies and personnel who participate in the Alabama Mutual Aid System and who give the extra time and effort it takes to train and facilitate the teams of all types and descriptions. Alabama is a safer place because of your sacrifices, efforts and expertise.

Alabama EMS History Project

Voices From Our Past

"History never repeats itself, but it often rhymes."

Possibly Mark Twain

EMS looks so forward to its potentials that it rarely looks rearward at its past. Alabama EMS is no exception. To do so is a travesty to those upon whose shoulders we stand as we promote our newest endeavors to save lives and ease suffering. In a series of articles each issue we hope to recognize those who were the first on scene to our history.

Montgomery Fire Rescue

Tracing the development of the Rescue Division within the Montgomery Fire Department

On May 5, 2023, an interview was conducted with Paul S. Harper, a real estate agent in Prattville, Alabama who was one of the first members of the Montgomery Fire Department's Fire Rescue program.

Mr. Harper recounted that he first joined the Montgomery Fire Department in 1974, at the age of twenty-one. He ultimately retired from Montgomery Fire Rescue in 1997, after serving twenty-three years and retired at the rank of District Chief. He then went on to work at the Alabama Office of EMS between 1997 and 1999, where he oversaw the ALS credentialing program. As part of his job, he developed the offline treatment protocols and the educational processes and testing necessary for credential personnel to use the treatment protocols (standing orders) in lieu of physically calling the emergency department physicians to request orders to perform procedures and administer medication. Before physicians would trust treatment by standing order, they required that a baseline of acceptable performance be established, which was the primary function of Mr. Harper's role at the State.

Mr. Harper explained that in his initial days at Montgomery Fire, the role of rescue was performed primarily by ambulance services, particularly by City Ambulance. He stated that if a patient was entrapped in a motor vehicle accident, for example, extrication was facilitated by wrecker services in cooperation with the ambulance service, or if necessary, a Montgomery Fire truck company was dispatched. He also explained that tools available to the fire department was limited to pry bars and other basic implements. He elaborated that the truck companies primarily functioned to rescue and remove victims from house fires and other traditional roles.

Mr. Harper stated that before his time in the fire department, during the years of hearse-type ambulances, that many firefighters would work part-time as drivers and attendants, even without training or with minimal first aid training. He recounted that some of the first Firemedics had performed those jobs prior to EMS training becoming available and the development of the Rescue program.

When asked to explain what the stimulus for first development of the Rescue program was, Mr. Harper stated that Chief J.A. Odom was watching television at home and happened to watch the television show EMERGENCY! (1972-1979) and thought that Montgomery could benefit from a similar program. Chief Odom contacted the Memphis Tennessee Fire Department and inquired if they were developing such a program and how

they were doing it. Chief Odom arranged for the first group of firefighters to attend EMT-through-Paramedic classes at the University of Alabama at Birmingham with expenses paid by Montgomery Fire Department.

In 1975 the original group of firefighters were sent to Birmingham to undergo Paramedic training at the University of Alabama at Birmingham. The first group was comprised of W.R. Mitchell, J.D. Colson, R.E. Welch, C.B. Andrews, D.L. Groover, J.P. Williams, B.L. Coburn, W.V. Arnette, and Max Hinton.

Mr. Harper recalled that when the first group completed training and returned to Montgomery as Paramedics, the Fire Department really did not have any equipment for them. In 1975 they manned one rescue unit in an older Police Chief's car, which was a Plymouth sedan, and the equipment available to them was minimal. He humorously remembered that all of the supplies, such as intravenous fluids and infusion sets, which went on to be carried in tackle-type boxes were first carried in brown paper grocery bags. He laughed that the hospitals first supplied replacement materials that were used on patients but that if the crews had to answer calls in the rain the hospitals ended up having to resupply everything. The supplies eventually were placed in fishing tackle boxes after one of the Firemedics, possibly Pat Williams, brought one from his house to protect the expendable supplies from the elements.

Mr. Harper recounted that the very first "true" rescue truck the City of Montgomery attained was a crash truck which was purchased through a federal grant. In order to comply with the parameters of the federal grant, the Fire Department agreed to answer emergency calls in the county. In return the City of Montgomery received the crash truck, a ladder truck and a pumper truck. The crash truck was stationed at Fire Station 10 on Cleveland Avenue (now Rosa Parks Avenue) and designated Rescue 91. Station 10 has remained in service and houses an EMS rescue truck at the time of this writing. It has historically been one of the busiest EMS stations in Montgomery.

The second rescue unit went into service in 1976 and was located at Fire Station 3 on Carmichael Road. Mr. Harper commented that he entered the EMS Division of the Department at about this time. The second vehicle was designated as Rescue 92 and was designed to be a box-type bread delivery truck. Mr. Harper stated that his role on his unit as an EMT-A was to drive the rescue truck and assist the Firemedic personnel. He recounted that although the vehicle had more equipment space than the crash truck, one of the issues with utilization of that vehicle was that it had two sliding doors on either side of the driver and passenger seats and the storage portion was open throughout and had a door on the rear. Many of the crew personnel had a habit of placing their hands on the front of the door frame when the vehicle was in motion to steady themselves during response. He stated that when the vehicle was forced to stop suddenly the sliding doors would slide forward, subsequently injuring the hands and fingers of several of the crewmembers.

Mr. Harper remembered that the administration of the fire department was uncertain how to lead the new Firemedic personnel, as they had no experience in that sort of endeavor. The Firemedics were sometimes considered "oddballs" within the rank and file of firefighters, and due to the unprecedented run volume of the rescue units they were constantly alarmed out. Coincidently, the city government also went through a structural transition at about this time. Jim Robinson served as mayor of Montgomery from 1971-1977. Toward the end of his tenure the system of government transitioned from a Commission system to a Mayor-Council system. After reviewing the expense associated with operation of the Firemedic program, which did not generate city revenue, the Council voted to discontinue city-funded EMS service to the citizens of Montgomery. Whereas the program was an enigma of sorts to the established rank and file of the fire department, the citizens of Montgomery had come to expect and depend upon the rescue services provided. The announcement of, and the actual cessation of, Firemedic services to the city resulted in an unprecedented outcry by citizens throughout Montgomery. The result was the reactivation of the Firemedic program within five or six days. Although the cessation of Firemedic services

tarnished Mayor Robinson's image for the voters, he was later embroiled in unrelated controversial legal issues and resigned in 1977. His replacement was a member of the council who ultimately became the Firemedic program's greatest advocate, Emory Folmar. Mayor Folmar served from 1977 to 1999, which is the longest tenure of any Montgomery mayor to date. Under his administration the Montgomery city services, especially the fire and police departments, rose to unprecedented levels of support, efficiency, and effectiveness.

Dr. William House Chambless (1929-2006) a Montgomery surgeon, and for many years Montgomery County Coroner, served as the first medical director of the Montgomery Fire Department Firemedic program. Mr. Harper stated that Dr. Chambless was very helpful during the initiation of the Firemedics and instrumental in the reinstatement of the Firemedics after the cessation of services occurred. According to a conversation many years ago with Retired Captain W.R. Mitchell, who was the Captain of the Firemedics at the time, Dr. Chambless made a statement to the Montgomery City Council during a meeting regarding funding of the fledging Firemedic program. Mr. Mitchell reported that Dr. Chambless held a laryngoscope up in view of the members, explained what it was and how it worked, and then exclaimed "If 'you' have a heart attack and collapse in cardiac arrest, the person who knows how to use 'this' in the field can make the difference between life and death." Mr. Harper stated that he believed Dr. Chambless' message to the City Council was a key factor in approval of funding.

After the first group of nine firefighters attended UAB, returned and initiated the Firemedic program, a second group of eight firefighters were sent. The budgetary issues described earlier made it necessary for the group, who continued to receive their salaries, to pay for their tuition, room, and board personally. This was under the condition that the city would reimburse them for their expenses. Mr. Harper remembered that the approval to reimburse them was never received. Mr. Harper stated that he was one of four firefighters that were sent up in the last group. He graduated in June of 1977. Subsequently applicants were sought for hiring that were already licensed as Paramedics. Those Paramedics were hired as civilian Firemedics, as they were not expected to double as firefighters. At this time the civilian paramedics were uniformed in green shirts, after which for a time all the rescue personnel were put in the same green shirts. The picture at right, circa 1978, depicts Mr. Harper, a firefighter qualified Firemedic sergeant with civilian medics Bob Smith and James Moulton.

Mr. Harper reported that the fact that the civilian paramedics were hired at a higher rate of pay (approx. 17% differential) caused mild contention among some fire-fighters. As a result, the Firemedics were nicknamed "The Leprechauns" at the stations due to their green uniforms.

At Left: Circa 1978, picture of Firemedic sergeants Groover, Harper, Coburn, Welch, and Williams. Taken in front of the Montgomery Civic Center. Note that the original vehicles had been replaced by truck-body compartmented response trucks by the time the pictures were taken.

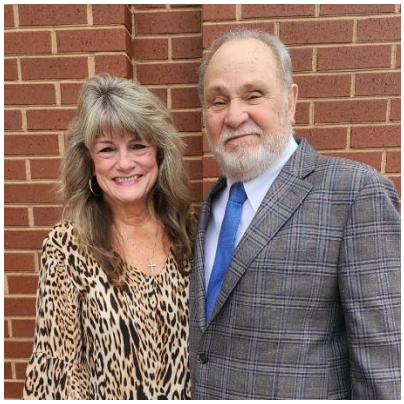
Mr. Harper recounted that he became interested in seeking training in EMS while stationed at Truck 43, a traditional ladder truck company. He reported responding to a housefire where a man had struck a match in a gas-filled house where he was seated on his living room sofa. The explosion blew him through the front picture window of the house and out into the street. Upon arrival the truck officer assigned Harper, a firefighter with basic first aid training at the time, to care for the injured man while the rest of the crew extinguished the fire. He remembered feeling helpless and overwhelmed due to his lack of training in trying to care for the man. He stated that he returned to the station that night and was very distraught. He spoke with one of the Firemedics about the situation and was advised to attend the EMT-A classes that Mr. Hill, J.D. Colson and J.E. Ray were teaching at St. Margaret's Hospital (then on Adams Avenue in downtown Montgomery). His original intent was only to seek training to assist in his firefighting role, but after he completed his training, he was assigned to the Firemedic program and ultimately trained in the final UAB group.

Many people in and around the Montgomery area entered EMS through the classes held at St. Margaret's Hospital. EMT-A was the only level available for the first few years. St. Margaret's was very proactive in the development of the EMS System in the area and provided one of the designated emergency departments during the years the City of Montgomery mandated the rotating emergency room system, or "ER of the day". Below is a view of the hospital at the Ripley Street entrance, and Adams Avenue at Ripley Street, at approximately the time EMT-A classes were held within the facility.

In June of 1977, upon graduation from UAB Paramedic training, Mr. Harper was asked by J.D. Colson to come and assist instruction of the EMT classes at St. Margaret's. In about 1978, J.D. Colson reached out to Alabama Office of EMS Director Art Harmon to brainstorm how to facilitate the progression of availability of training in Montgomery beyond EMT level. The solution reached was to conduct satellite programs through Dothan's George Wallace College. Colson, Ray, and Harper then moved their operation to a local technical college. To facilitate the larger classroom requirement for multiple simultaneous classes, the program was moved to Trenholm Technical College on Airbase Boulevard, where grant funds were used to build a new EMT training building. Intermediate and then Paramedic classes were instructed through George Wallace College until permission was attained to transfer the auspice of the program to Trenholm Technical College. Upon transition of the training program to Trenholm, the original Program Director was J.D. "Jack" Colson. In late 1979 the responsibility of Program Director transferred to W.R. Mitchell, who had recently retired from the fire department and could do the job full time. Shortly thereafter, J.D. Colson was promoted to District Chief and remained the officer in charge of Montgomery's Firemedic Division.

FRONT: Firemedic Sgts Williams, Welch, Coburn, and Harper
SECOND: Lt. Ray, Chief Odom, Mrs. Ruby Barlow and Captain Colson
THIRD: Firemedics Sgt. Groover, Marshall, Varney, Prichard, Kunert, Mathis, Smith, Brown, Moulton, Duck and Hubbard

In subsequent years, adding to Rescue 91 and Rescue 92, Montgomery instituted Rescue 93 (Lower Wetumpka Road) and then Rescue 94 (Normal Bridge Road). By the time Mr. Harper retired in 1997 a fifth unit, Rescue 95, had been placed at the station on Forest Avenue. As previously stated, he retired as District Chief of the Firemedic Division. After leaving the Office of EMS in 1999, Mr. Harper considered employment in EMS instruction, provision, or administration. He decided to vary his life's experience and to work in an environment where he could effectively function as a single father. He accomplished that goal by beginning a career in real estate. At the time of this writing Mr. Harper is Broker Owner of RE/Max Properties in Prattville, Alabama.



AT LEFT: Paul Harper and his wife and partner Debbie Whitehouse

The Alabama Office of EMS would like to thank Mr. Harper for his time and for providing historic photos of the Montgomery Firemedic personnel. We would also like to thank him for his passion for the profession of EMS and for the countless lives he has saved and positively influenced.