by saying that they collect only about 40 per cent of their bills (interestingly enough, only a very few public or private medical plans cover ambulance costs). And there are further problems. Because of poor communications equipment and organization, or none at all, most of these privately owned vehicles arrive at the scene of accidents, or to pick up the seriously ill, too late.

THIS is only part of the story. Far too often the personnel operating ambulance vehicles are in no way trained to handle or deal with the sick or injured. Also, the vehicles, in many instances hearses hurriedly converted to ambulance service, are in no way designed or equipped to play their proper part in transporting and treating the people.

It is unrealistic to lay sole blame on the private ambulance operators and attendants in Canada and the United States. Basically, the public is not aware of the situation—the system takes care of that. Different levels of government disclaim all financial or moral responsibility.

With a few notable exceptions, we find no public standards relating to emergency treatment personnel, communications, and the reorganization, staffing, and equipping of emergency units in hospitals. The medical profession has persistently avoided contact with ambulance services. Thus, private services rarely, if ever, obtained training to upgrade their treatment facilities. Even if they had, it is questionable whether the jealousy of the medical profession would have allowed ambulance attendants to "practise doctoring" by even applying splints or stopping bleeding.

The emergency health services division of the Ontario Hospital Service Commission recently started training casualty care attendants, thus initiating a new para-merical discipline. Tragically but predictably, the medical profession for the most part has not only rejected this new concept, but has publicly berated the emergency health service representative for instigating this progressive change in medical tradition.
