



Driving The Point Home

In the last several months there has been much discussion on emergency driving. It has become a standard discussion topic as I present across the state. A web article from EMSNetwork states that “increasing traffic and road speeds coupled with poor or obsolete emergency vehicle training add up to increased damages, injuries and deaths from ambulance crashes. Nationally there are over 6,500 reported emergency vehicle crashes every year (18 per day), injuring 10 per day and killing over 36 per year” (http://www.emsnetwork.org/artman2/publish/article_26416.shtml).

I happen to believe that while there is a national trend of increased accidents with ambulances, our state is relatively safe. This can probably be attributed to the safety record of drivers in general (after all, we have low personal auto insurance rates because we inherently are safe drivers). Unfortunately, those involved in any way with these emergency vehicle crashes may find it hard to believe we are truly safe.

This month, I would like to share some interesting ideas that I have come across. These are not necessarily the opinions of mine, the state office staff, or indicate a direction on this issue. They are presented for discussion and contemplation only.

In the early days of EMS, we responded emergent to every call regardless of the complaint. Our care consisted of possibly oxygen, but mainly driving emergent and as fast as we could to the hospital before something worse happened. As the profession grew, we became aware that we could stabilize patients and not have to drive with lights and siren to the hospital on all calls. As medical priority dispatch has evolved, we are now responding emergent to fewer calls.

We as professionals still perpetuate the concept of, “it’s an emergency until we find out otherwise.” However, many providers, directors, insurance companies, lawyers, and especially victims and their families are finding that this attitude can be dangerous. When we drive emergent, we are putting ourselves, the pub-

lic, and ultimately the patient at risk. Many responders start in this profession because they want to drive fast and not have to obey traffic laws. While this is probably a true statement for most of us when we begin our EMS journey, one could find out very quickly that this attitude will only shorten your EMS career.

So where is the controversy? There are three things that need to be in place to counter all these issues and create a safer response. Number one, implement priority dispatch; number two, change the EMS culture; and number three, educate the public. Let’s take these in order and see how they fit together.

Priority dispatch has been a hot topic throughout this state and many others. 9-1-1 systems have felt in the past that there is significant liability in providing pre-arrival instructions and making a response decision with limited knowledge. This feeds to the, “it’s an emergency until otherwise told.” However, if one knows that using an oral airway will open a passage for air and prevent a patient from going into respiratory arrest, why would we not want to use the airway? We know that priority dispatching and pre-arrival instructions make a difference – why are we not all using them? If you use a designed commercial system for priority and pre-arrival care, the liability lies with the vendor of the program, not the dispatch center. Yes, that is correct – you are better protected by having a system in place than not! The only other common response is that we cannot afford the cost of initial and continued training for dispatchers. Yes, that is a real problem. But where there is a will there is a way. What’s that saying, “necessity is the mother of invention?” In today’s age of technology, it would not be unreasonable to have this as an expectation from the public, just as cellular 9-1-1 is an expectation (by the way, extending the cellular 9-1-1 tax for an additional year was a proposal to fund training and certification of emergency medical dispatchers).

So onto the EMS culture. Within our circles, we like to drive fast and get to the patient as soon as possible. As I mentioned above, this is

perpetuated by our assumption that every call could be a life or death situation. After all, dispatch is always accurate with the complaint, right? Priority dispatch does help, through focused questions, to arrive at a fairly accurate complaint. So that issue aside, how often do you get to a call that is truly a life or death situation? I would venture a guess that greater than 80% of all ambulance calls are non-life threatening and could have had a non-emergent response. If I have a laceration that is under control with direct pressure, will an extra few minutes cause more harm? Priority dispatch and pre-arrival instructions can reduce the need for emergent response and reduce the risk of a vehicle accident. We need to be real and respond appropriately. Not all calls are an emergency!

Let’s talk briefly about patient transport with lights and siren. There is a system that has a protocol that all cardiac arrest patients are to be transported to the hospital non-emergent. Think about that for a minute before you react. A cardiac arrest patient is technically dead. If your system is ALS, all of the medications and most of the simple interventions are available in the squad. The increased risk of injury to the providers doing CPR in the back of a moving ambulance, as well as the risk to other vehicles, is great. If the patient is technically dead, there is little more harm that can be done in the extra few minutes it will take to transport non lights and siren. I know, this rubs against our culture and our desire to help patients.

So now, the final approach: If we implement the above suggestions, we now have a problem with public perception. Over these 40 years, we have developed an expectation by the public that as soon as they call for an ambulance, we are responding as fast as we can because “it’s an emergency.” With the safeguards in place, most emergencies can wait up to 10 or 15 minutes for an ambulance to arrive. The public expects an immediate emergent response and we would be tasked with educating them that we will respond in a safe and timely manner. After all, how many times have you been asked by the caller to shut down your