

EMERGENCY MEDICAL **DISPATCH!**

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NAVIGATOR '96 CONFERENCE ISSUE



"State of the Academy"

• Robert L. Martin, Executive Director

As this newsletter goes to press, we are processing a group of newly certified EMDs that will push current Academy membership past 17,000. This is not a running total of EMDs ever trained, but represents currently certified membership, dynamically expanding by a growing number of initial certifications, while being bolstered by a better than 75% recertification rate. This is something that we can all be extremely proud of.

It's important to note that the Academy is the only organization dedicated solely to the professionalism, science, and standards of EMD. With more than 17,000 members, the Academy is four times larger than NAEMT and eight times larger than the EMD membership of APCO. Our strength lies in the combined dedication and voice of our nationally and internationally certified Emergency Medical Dispatchers.

The Academy provides several support services to its membership and is continuously striving to improve and expand itself. Some key issues the Academy is currently addressing include:

- (1) *Expanded College of Fellows and EMD Standards Boards,*
- (2) *Updated EMD Curriculum and Training standards,*
- (3) *Updated EMD Certification and Recertification standards, and*
- (4) *Refined "Center of Excellence" Accreditation standards.*

These evolving standards are reviewed by specific sub-committees within the Academy and ultimately by the College of Fellows, which acts as our final standard-setting group. The College is a unified international scientific body of 45 voluntary experts who wish to share their combined knowledge around the world. Ten recent past presidents of the NAEMD, NENA, NAEMSP, NAEMT, AAA, and ACEP are current fellows.

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With more than 17,000 members... our strength lies in the combined dedication and voice of our... certified EMDs

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An official Academy position...

Follow the Protocol and Avoid Liability

• Jeff Clawson, MD

Earlier this year I was approached by the EMS Coordinator of a Fire Department in the Midwest. Their department was implementing a two-tiered response system, utilizing the MPDS. This coordinator shared with me some concerns that arose about response coding. *First*, if Dispatch codes a call COLD and the officer in charge of the fire apparatus decides to run HOT anyway, what is the potential liability exposure of the City and of the officer involved? *Second*, if Dispatch codes a call COLD and the officer runs COLD, but upon arrival finds a medical situation,

not like what they were told, what potential liability exposure might arise? These are good questions that I've been asked before in varying ways.

In answer to the first question, in my opinion, there is absolutely no reason for station officers or crews to determine response mode and configuration where the *Advanced* MPDS is in place and functioning. If department policy states that response mode (HOT vs. COLD) is determined by the EMD, a station officer's decision to do otherwise would be a direct violation of policy and procedure. In support of the EMD as this decision-maker, no one can know more than the EMD prior to arrival since the EMD is the only person who has talked with and interrogated the caller. The EMD's selection of a determinant code-based

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State of the Academy... Follow the Protocol...

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The origins of the NAEMD lead back to the first medical dispatch protocol and training course that was developed by Dr. Jeff Clawson, et. al. in Salt Lake City. The Utah State Bureau of EMS then later established the first Statewide EMD Rules and Standards in 1983, codifying the "EMD" as a governmentally recognized medical professional.

Because of this early activity, Dr. Clawson and several others began discussions regarding the feasibility of a national organization specifically for EMD. In 1987, efforts to create a support and information-sharing group resulted in establishment of the "North American EMD Network," the immediate precursor to the NAEMD, which was founded the next year.

Out of these humble beginnings the Academy has today emerged as a standard-bearer in the tradition of recognized expert organizations like the American Heart Association and the European Resuscitation Council. Patterned after the AHA's Emergency Cardiac Care Committee (which recognizes a single CPR protocol, a single ACLS protocol, and a single BLS protocol), the Academy will continue to further the unified acceptance of the *Advanced Medical Priority Dispatch System (MPDS)* EMD protocol, as well as related practice standards for Dispatch Life Support (DLS). To expand on NENA's well-known mission statement, "One nation, one number" the NAEMD endorses, "One protocol, one EMD standard."

The Academy is now beginning to focus on consistent recognition of EMD across country, state, provincial and other governmental boundaries

In addition, just as was accomplished by the National Registry of EMTs several years ago, the Academy is now beginning to focus on consistent recognition of EMD across country, state, provincial and other governmental boundaries. This process began with Utah, Colorado, Delaware, and the Province of Quebec. Now, other areas are lending their support, and the Academy has recently approached every state for consistent recognition of its standards for EMD curriculum, certification (incl. initial testing), instructor status, recertification and continuing education.

Progress has been limited by how each state or province is individually recognizing EMD, but encouraged by recently published national EMD standard-supporting documents from such organizations as ASTM, NIH, NAEMSP, NASEMSD, and the USDOT (NHTSA). By working directly with government representatives and allied professional organizations, the Academy hopes to continue to strengthen the acceptance of EMD as a unified international practice standard. ■

The Academy will continue to further the unified acceptance of the Advanced MPDS

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response is clearly the correct process since these responses are pre-planned by the department's management in conjunction with sound medical oversight input.

Should an officer change any response for his own reasons, in violation of procedure, it would be very likely that any liability incurred would rest on him. However, if it could be shown, perhaps by the department's lack of corrective action in a similar or threatened situation, that the department could have foreseen that he would violate this procedure then the department as "captain of the ship" might incur liability. In this case, having an approved MPDS, training the EMDs, and also having a policy and procedure in place clearly stating who has the responsibility for response configuration and mode determination, would establish a rational and non-arbitrary process that would be legally defensible as well as correct.

The second question is an interesting converse to the first. It is apparent that the crew would have no liability for following policies and procedures and responding COLD as directed. What is important is that the EMD *complies* with the protocol in asking the listed evaluative questions and then codifying the data obtained. It is apparent that the EMD cannot be a prognosticator or clairvoyant in regards to scene findings. The dispatcher is only required to make a *reasonable* determination of the patient's problem based on the available information. If the EMD followed the key questioning and picked the closest of the listed determinant codes (without going "under"), then the EMD would have met his/her duty to perform based on their training and procedure (the protocol). While in some instances, scene findings may be different than initially reported by the EMD, that does *not* mean that the EMD made a "negligent" mistake.

Field crews should be inserviced to understand that once the EMD has evaluated the patient and scene, three things can happen in the ensuing time of mobilization, response, and initial patient in-person evaluation — *the patient can get better, get worse, or stay the same*. The failure of crews to appreciate this obvious but not well understood fact can make life easier for everyone and prevent inappropriate criticism of dispatch from the field.

It should be pointed out that there has never been a case that has ever claimed negligence for *not* responding HOT, much less succeeded in proving it. Furthermore, no study in the medical or public safety literature proves, or even states, that lights-and-siren saves *significant* time. The careful use of lights-and-siren as warning devices now more than ever requires their measured medically-correct use to prevent the terrible consequences of the predictable occurrence of emergency-vehicle collisions. ■

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DISPATCH! Newsletter

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DISPATCH! is the official publication of the National Academy of Emergency Medical Dispatch (NAEMD), a nonprofit, standard-setting body for Emergency Medical Dispatcher training curricula and EMD certification and recertification requirements. The Academy provides EMD certification and recertification for applicants that pass the Academy's respective examinations. Through its College of Fellows and other internal committees, the Academy addresses itself to scientific issues related to emergency medical dispatching. The College of Fellows is also responsible for the ongoing assessment and modification of the *Advanced Medical Priority Dispatch System (AMPDS)* Protocols.

It is the editorial policy of this newsletter to publish articles and correspondence of interest to the EMD community. Content may cover such topics as caller interrogations, pre-arrival instructions, legislative and legal developments, personalities, protocols, and other topics of general interest. Submissions for publication, including articles, essays, guest comments, and letters to the editor, should be typed, double-spaced, on 8½" x 11" paper, and are subject to editing. ■