"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, NAEMS, NAEMT, AAA, and ACEP are current fellows.

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 determinate code-based (continued on page 3)

There is absolutely no reason for station officers or crews to determine response mode and configuration...
A Parallel Awakening

*Alexander Kuehl, MD, MPH, FACS*

In both the old world and the new world, there are major changes occurring in the provision of prehospital care. I’m pleased to report that the importance of good-quality EMD continues to be recognized around the world. But before I discuss some of these parallel changes, I want to remind the Academy members of a few important definitions, mostly reflecting my bias.

- **Prehospital Care**: This term best represents the broad description of EMS. Although some folks prefer “out-of-hospital care,” I think it is an unnecessary step, but future usage will tell.
- **Medical Oversight**: This term gives us a fresh start in the confusion of “medical command,” “medical control,” and “medical direction.” Medical oversight is broad and includes the medical, legal, and moral responsibility for all the medical aspects of prehospital care, including direct and indirect medical control.

That said, it is striking to observe two large EMS systems, one in North America and one in Spain, and how they have recently changed; both of them independently realizing that better and more efficient EMD is critical for their success. In both countries, a gradual but real move away from the public delivery of healthcare and hospital services has proved to be a significant impetus to the initiation of changes and improvements.

In Catalonia (Barcelona), Spain, the public EMS service (“061” rather than “911”) has recently contracted with a local consortium of private ambulance companies to have them deliver the 93% of prehospital care that are not major emergencies, including all situations that are not limb- or life-threatening. One thing that was required was a major upgrade of the call receiving, call prioritization and unit dispatching functions. It is clear to medical oversight and administration that the process of upgrading EMD must be continuous.

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MPDS Q&A

What to do about CDE...

*Steven M. Carlo, Vice President*

During EMD courses I’m frequently asked questions concerning recertification and continuing education (CDE). The Academy has a list of what areas may qualify for CDE and of the types of training to apply; however, this list is composed of very general guidelines and a number of agencies are unclear on how to proceed.

I’ve found that, currently, most CDE is performed in-house. Often these CDE sessions are small groups or done singly to facilitate schedules and other economic realities. The occasional ride-alongs, viewing videos, or reading journal articles lend themselves to this type of learning. For small departments, these CDEs are also more economical than formal monthly training sessions and group meetings.

The NAEMD is currently working to standardize acceptable experiences as demonstrative of learning, by working with other EMS standard-setting organizations. Once complete, the benefits will include having both initial courses as well as refresher training with recognized and multi-state transferable CDE credits.

A yardstick that can be applied to all C.E. is validity.

While the Academy has been recognizing this education, it’s an added advantage to have other independent bodies authenticate these Academy efforts. An effort is underway by the Curriculum Committee to tighten the existing criteria and to create an “off-the-shelf” program that will conform to all standards. An advantage to tighter CDE standards will be better acceptability and less time involved in creating. Local customization will be encouraged within guidelines. More energy can be devoted to performing the dispatch service without worrying over CDE compliance.

A yardstick that can be applied to all continuing education is validity. How valid is this learning or re-learning experience for the type of work being performed? For example, while it may be nice to know about information available through a computer criminal background check, it has limited validity for EMDs in commercial ambulance services, or dedicated fire/medical dispatch. This would of course be valid for law enforcement/medical dispatch centers. Similarly, a lecture or article about the signs and symptoms of a stroke would be more appropriate than a discussion of angioplasty versus “roto-rooter” in blocked arteries.

Please keep in mind that your dispatch education should continue after the third year of an EMD course. This is merely the beginning of a life-long learning journey. May you navigate your journey well!
State of the Academy...

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The origins of the NAEEMD 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 NAEEMD, 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 NAEEMD endorses, “one protocol, one EMD standard.”

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 (inc. 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, NASEMDS, 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.

Follow the Protocol...

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The Academy will continue to further the unified acceptance of the Advanced MPDS 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 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 coding 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 instructed 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. Field crews should appreciate the 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.
Parallel Awakening...

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Meanwhile in New York City, your Academy President (me) was very proud to be one of many midwives to the newly merged 911 system. In March, 1996, NYC*EMS was folded into the NYC Fire Department. The life-savings by fire department first response (including automatic defibrillation), and the cost-savings by consolidation of services, were only two of many reasons why the merger was proposed in the Mayor’s plan for his first term. The 911 system now has become a three-tiered system and, as you might expect, a major reengineering of EMS prioritization and dispatching is occurring.

In summary, at this time it is still unclear whether these two prominent systems will adopt existing proven approaches to prioritization and dispatching, but it is clear that there is a need to assure high quality and consistent EMD prior to incorporating the necessary changes and enhancements. Nevertheless, I couldn’t help but be struck by how easily existing proven EMS systems (such as the MPDS) could be implemented, and yet how there always seems to be some resistance toward using any type of system that is not the agency’s ‘own,’ no matter how well-proven.

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Upcoming Courses

For more information on these and other approved EMD Certification Courses call Medical Priority: (800) 363-9127:

- Aug. 2-4 South Bend, IN
  St. Joseph County Fire Dispatch
- Aug. 4-6 & 8-10 Skokie, IL
  Mercy Ambulance
- Aug. 5-7 Albany, GA
  Albany Public Safety
- Aug. 5-7 Rio Rancho, NM
  City of Rio Rancho Dept of Pub. Safety
- Aug. 5-7 Twin Falls, ID
  Southern Idaho Regional Comm. Center
- Aug. 12-14 Alpena, MI
  Alpena Co. Central Dispatch
- Aug. 14-16 Amarillo, TX
  NW Texas Health Care Sys. Ctr. for EMS
- Aug. 15-17 Alpena, MI
  Alpena Co Central Dispatch
- Aug. 15-17 Watertown, NY
  Guillfoyle Ambulance Service Inc
- Aug. 16-18 Ste. Genevieve, MO
  Ste. Genevieve 911
- Aug. 19-21 Jasper, GA
  Pickens County 911
- Aug. 19-21 Scottsboro, AL
  Univ. of AL School of Med./Huntsville
- Aug. 20-22 Gaffney, SC
  Cherokee County 911
- Aug. 23-25 Furlong, PA
  OMNI Mobile Health Systems
- Aug. 26-28 Northbrook, IL
  Northbrook Fire Dept for RED Center
- Aug. 27-29 Snowbird Resort, UT (Navigator ’96)
  Medical Priority Consultants, Inc.
- Sept. 11-13 Portland, ME
  Portland Police Dept.
- Sept. 11-13 Aztec, NM
  San Juan Co Comm. Authority
- Sept. 13-15 Goodland, KS
  Sherman County Communications
- Sept. 23-25 Gadsden, AL
  Etowah Communications District
- Sept. 25-27 Augusta, GA
  East Central Georgia EMS
- Sept. 25-27 Edmonton, Alberta, CANADA
  Northern Alberta Institute of Technology
- Sept. 27-29 Easton, MD
  Talbot County Emergency Mgt. Agency
- Oct. 21-23 Youngstown, OH
  Mahoning County 911
  & 28-30

Footnotes:
The following organizations offer training & services of interest to Academy EMDs.

University of Iowa—EMS Learning Resource Center
Mike Hartley (319) 335-2597.
Aug. 6-8 Charles City, IA
Sept. 10-12 Monticello, IA
Sept. 16-18 Des Moines, IA
9/30-10/2 Storm Lake, IA
U. of Alabama-Huntsville
Sheila George or Rick Beck (205) 551-4413.
Columbus State Comm. College (Ohio & region)
Art Gholian (614) 226-7400.
Palm Beach Community College (Florida & region)
Barry Duff (407) 439-8213.

Team Dispatch—FL Promotes EMD & offers awards as part of a free incentive and recognition program. Send in your success stories for review. 1004 Green Pine Blvd., H-1, West Palm Beach, FL 33409. Michael Richman (407) 687-9113.

Dispatch Monthly Magazine “Just For Dispatchers & TC’s!” Subs. only $20 for 12 issues.
Write to: Mr. Alan Burton, P.O. Box 1153, Benicia, CA 94510—(707) 747-0540.

Florida EMS Clearinghouse Information service providing EMS-related journal articles/documents for small or no fee. Sue McCauley or Tonya Keiffer (904) 487-1911.