

EMD Risky Business?

*The Risks Associated With the Failure To Correctly Implement
A Formal Emergency Medical Dispatch Program*

By Fred Hurtado

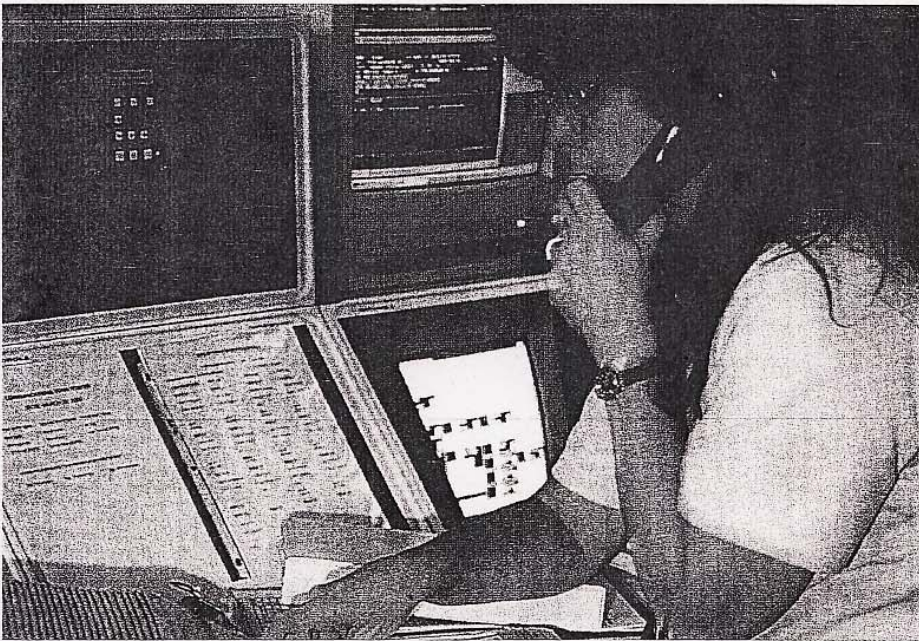
This article started with a conversation I had with a colleague. We were commiserating with each other about our increasingly heavy workload as providers of expert witness testimony in 9-1-1 EMS dispatch lawsuits. The stories would just curl your hair ... failure to dispatch EMS resources to life-threatening emergencies, delays of as long as 40 minutes in dispatching EMS resources even after repeated calls for help ... dispatchers refusing the caller's pleas for CPR instructions ... the list just goes on and on.

I see the lawyers, and those of us who assist them, as kind of like a clean-up squad. We didn't create the mess, but we help sort it out, bring some sense of closure to the survivors and try to do what we can to make sure that such a tragedy doesn't reoccur. These tragedies are inflicted on an unsuspecting public by the very agencies that are duty bound to help them.

My colleague and I ended our conversation by wishing that the entities responsible for providing 9-1-1 EMS dispatch services to the public would put us out of the expert witness business. Unfortunately

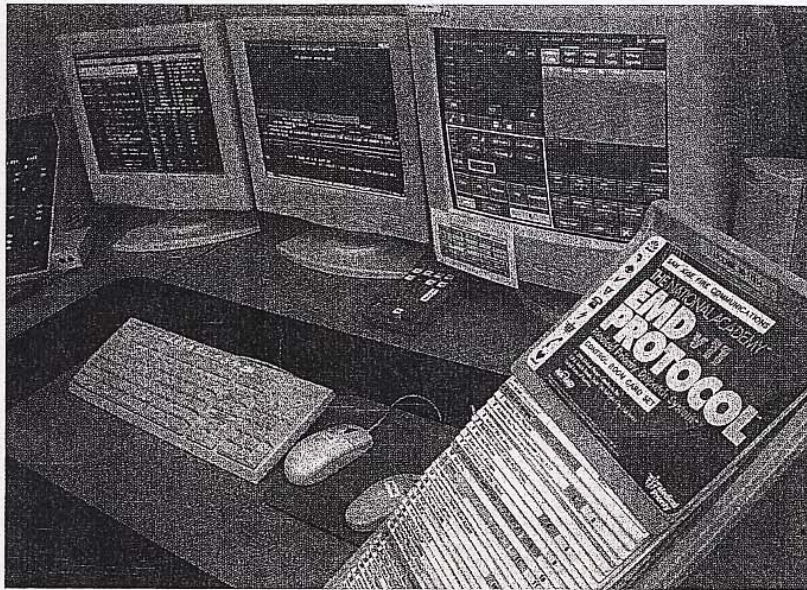
we both know that in all too many cases, some 9-1-1 EMS dispatch agencies will do the right thing only when it becomes demonstrably cheaper than doing the wrong thing. I frequently listen to agency officials moan about how they were just unlucky, and that the horrible EMS dispatch incident could have happened anywhere, and that it really wasn't anybody's fault. I don't feel one bit sorry for them. I hope the taxpayers hold them accountable for wasting their money, and I go home and sleep the sleep of the just.

The courts are the ultimate venue for grieving families who want to find someone to blame for the needless loss of their loved one. They sue for negligence ... and municipalities and agencies responsible for dispatching EMS resources incur astronomical costs in both defending themselves and paying out huge sums in punitive damages. The most visible and recent example is the City of Chicago. Juries have found against the City in a number of relatively recent 9-1-1 dispatch-related lawsuits. In *Gant vs. City of Chicago* the family of a deceased asthmatic, 19 year old Douglas Gant, sued for \$10 million after having to call 9-1-1 three times for an ambulance and failing to receive pre-arrival instructions from a dispatcher on each occasion. The jury awarded the plaintiffs \$50 million dollars! Although a judge recently set aside the jury award as excessive (a lesser amount will be determined), the jury's decision demonstrates how they felt about the story they heard at trial. In *Cooper vs. City of Chicago* the jury awarded \$3.06 million to the family of a man who bled to death from a leg ulceration. Chicago



Hamilton County (TN) dispatcher Debbie Anthony was photographed while providing telephone CPR instructions for a 22-year-old male who had overdosed. Despite the international validation of such programs, many agencies are still reluctant to adopt formal or even prioritized Emergency Medical Dispatching programs, often citing unwarranted concerns over liability.

KEN KERR



RANDALL LARSON

EMD protocols are based on nationally recognized and updated standards. Cardsets like these from Medical Priority are being used by more than 2,500 agencies. Liability can be incurred when these protocols are not implemented, are implemented and then ignored, or are implemented incorrectly.

Fire Department dispatchers had refused two requests for an ambulance response.

Chicago is certainly not alone. Los Angeles, Dallas, New York and a host of other cities, large and small, have had

“high profile” EMS dispatch incidents that wound up in court. The costs of the bad publicity that arises from these tragedies are two-fold. We now know that such suits cause other suits ... people read

the horrific newspaper article, recall their own similar experience and start looking around for an attorney. The cost of undermining the public’s faith in 9-1-1 systems is incalculable but real. It is both ludicrous and tragic because the solution exists that can absolutely prevent these tragedies from occurring. And yet they go on and on.

Twenty years ago Emergency Medical Dispatch was just a good, albeit unproven, idea. Simply stated, formalized Emergency Medical Dispatch programs utilize trained EMDs (Emergency Medical Dispatchers) to ask the right questions of 9-1-1 callers for EMS assistance; to send the appropriate resources; and to tell the caller what to do prior to the arrival of EMS resources. Over the course of the last twenty years, however, something very important has happened. *The theory and practice of Emergency Medical Dispatch have been validated in the peer reviewed medical literature.* Studies have been published in such peer-reviewed journals as *Prehospital Emergency Care* and the *Annals of Emergency Medicine* that demonstrate the efficacy of formal emergency medical dispatch programs. Dispatchers who

From Dumb to Dumber

James O. Page, *FireRescue Magazine*

Departments must intelligently dispatch 9-1-1 calls to avoid problems—even lawsuits

One of America’s major fire departments has lost several multimillion dollar lawsuits over its dispatching on medical emergencies. The problem started years ago when the city actively encouraged citizens to dial 9-1-1 for police, fire, and medical emergencies, without conditions or exceptions. Nationwide, 9-1-1 has become the universal symbol for help.

The city in question bought one set of protocols (flip cards). It then modified the cards and attempted to train its dispatchers about how to use them for calls requesting medical assistance. If used *properly*, the protocols would guide the interrogation process so the dispatcher could send emergency resources based on medical condition

and need. Also, the protocols could guide dispatcher in providing post-dispatch (prearrival) instructions to callers while emergency units responded.

The fire department in the opening example has provided emergency ambulance service for many years. For most of those years, the city’s leaders treated that service as a stepchild, responding to its need for more resources only when a publicized crisis occurred. Thus, as the public caught on to 9-1-1, demand for ambulance service increased much faster than the number of ambulances. So, the dispatchers became the pressure point. They started deciding who would get an ambulance and who wouldn’t. For those who didn’t qualify, the dispatchers offered a phone number for private ambulances.

Denying emergency ambulance service is always risky, but the risk can

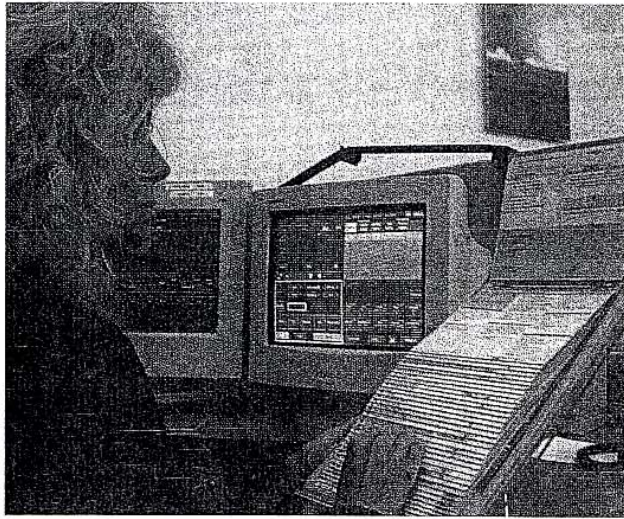
be managed by using time-tested protocols, thoughtful dispatcher training, good supervision, ongoing training, and a quality management program. In the city we’re talking about, the dispatchers received the flip cards but not much else. Before long, some of the dispatchers began freelancing, trying to apply the protocols from memory, if at all. If asked, most couldn’t locate the training manual issued to them when hired.

Because the number of ambulances didn’t keep up with population growth and demand, the dispatchers were instructed to ration them to only those cases that involved “life-or-death emergencies.” Their unskilled managers and supervisors criticized and disciplined quickly but rarely dispensed any positive feedback for jobs well done. Meanwhile,

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answer the public's calls to 9-1-1 for EMS assistance are performing a medical task. Nationally recognized EMS expert and attorney James O. Page has stated that there is an evolving legal duty to provide dispatchers with the tools they need to perform their medical tasks safely, competently and effectively.

Although this article may be somewhat provocative, it is really intended as friendly advice to 9-1-1 EMS dispatch agencies. *There is no longer any valid excuse for failing to correctly implement a formal Emergency Medical Dispatch program.* The textbooks have been written, the practice standards are published, and all of the relevant



RANDALL LARSON

San Jose (CA) Fire dispatcher Jennifer Burnham provides dispatch life support (DLS) via cardset protocols. San Jose is one of only 61 agencies to be named an Accredited Center of Excellence by the National Academy of EMD, a status primarily achieved based upon very high protocol compliance scores achieved through a defined quality management program.

national organizations that have anything to do with EMS and public safety telecommunications have publicly expressed their support for the implementation of such programs. The American Society for Testing and Materials (ASTM), the National Association of EMS Physicians, and the National Institute of Health, to name but a few, have all published standards documents on Emergency Medical Dispatch. If a given 9-1-1 EMS dispatch agency has not implemented a formal Emergency Medical Dispatch program it is misallocating EMS resources, exceeding national response time performance

a culture of discourtesy, disrespect, and impatience evolved in the dispatch center. It became an angry place and the unhappiness began to affect how employees treated callers.

The protocol (Flip) cards all bear the boldly printed words, "When in doubt—send." In several cases over a period of years, where the facts about the caller's information should have raised doubts, dispatchers deviated from the protocols and denied ambulance service to dying people. When that happened, the dead person's survivors usually got mad. The most effective tool they had was a lawsuit. After a few of those lawsuits cost the city some really big bucks, the people in charge went from dumb to dumber. They looked to the city's lawyers for advice on how to dispatch.

Prompted by the lawyers, the fire department now sends too many resources on most calls. These days, it's not uncommon to have a street filled with fire apparatus, ambulances, and staff cars for a relatively minor medical emergency. The firefighters know this over-reaction make no sense to anybody but the city's lawyers.

The whole concept of prioritized emergency medical dispatching (EMD) was carefully designed to provide the

appropriate response—without undue denials of service and without unnecessarily tying up too many resources. If prioritized EMD has a fault, it is the assumption that all public officials would be smart enough to implement and operate the system as it's supposed to operate.

In many places, the people in charge *are* smart enough to make prioritized EMD work and keep it working the way it should. Their success makes it easy to criticize those other places. Sadly, in too many of those other places, the dispatch center is controlled by people who seem to have been promoted or elected beyond their levels of competence. When incompetent leaders allow the system to go haywire, people get hurt and lawsuits occur.

When the lawsuits create a crisis, the leaders—oftentimes at the suggestion of their lawyers—overreact. Why must we make it so difficult? The public has been offered a service they can access by merely dialing three digits (9-1-1). They accept that offer more than anybody expected. So, there are two possible solutions: 1) revoke the offer, or 2) manage the demand for service intelligently. There's no politician foolhardy enough to revoke the offer, so that leaves only one option

The key word: *intelligently*. Dispatch centers cannot be a dumping ground for hand-me-down managers and supervisors. Dispatchers cannot be treated as disposable employees. The concept of prioritized EMD cannot be created as an optional procedure.

If dispatch errors cause big-buck lawsuits, employ a simple solution. Utilize a current, nationally standardized emergency medical dispatch program, learn how to do it right, treat dispatchers as professionals and train them accordingly, select and train good supervisors, and implement a continuous quality management program.

If those simple tasks are more than your organization can master, keep the checkbook handy. You'll need it.

James O. Page is the publisher/editor-in-chief of JEMS (Journal of Emergency Medical Services) and Fire/Rescue Magazine. His career in the fire service spans more than 40 years and he has served as a chief officer in three California departments. An attorney, author of several books, and frequent lecturer on fire- and EMS-related topics, he was the first recipient of the IAFC's "James O. Page EMS Achievement Award" 1995. This column is reprinted with permission and thanks from the August 2001 issue of FireRescue.

standards, causing needless emergency vehicle crashes, and needlessly jeopardizing and losing lives. The agency is, literally, a tragedy waiting to happen.

When the tragedy inevitably occurs, all of the texts, published practice standards, medical research, and national organization support documents will be presented as plaintiff's exhibits. Nationally recognized emergency medical dispatch experts will be interviewed by the local news media to explain how the tragedy could have been avoided. Agency representatives will be closely questioned about their knowledge of Emergency Medical Dispatch programs and will be required to explain why they haven't implemented one. The agency's existing emergency medical dispatch policies, procedures, and practices will be compared to the published texts and national standards documents.

About the only thing worse than not implementing a formal Emergency Medical Dispatch program at all, is implementing one and then not adhering to it. It is not unknown for 9-1-1 EMS dispatch agencies to implement the program on paper only. In other instances agencies have not provided the ongoing management support to ensure that the Emergency Medical Dispatch program is conducted properly. 9-1-1 EMS dispatch agencies will spend money on emergency medical dispatch—one way or the other. The money can be spent defending the agency against negligence suits, or the

money can be spent doing what the agency should have done in the first place. There is an old medical axiom that says, "Prevention is always the best and cheapest medicine."

There are a variety of options available for agencies that choose to implement formal Emergency Medical Dispatch programs. I encourage agency officials to closely examine those options. Agency decision-makers should review the texts, the practice standards and the published medical research. Keep in mind that, given the sheer volume of the public's demand for EMS service, bad choices will inevitably reveal themselves. Agencies and agency officials are ultimately responsible and accountable for the Emergency Medical Dispatch program choices that they make.

For those agency officials who choose to continue to visit unnecessary harm on both the EMS system and the public let me conclude by saying, on behalf of those of us on the clean-up squad, I look forward to meeting you. ■

In a twenty-five year career in EMS, Fred Hurtado served as an EMT, Paramedic, EMS administrator and manager, emergency medical dispatch consultant and state EMS official. In 1997 Mr. Hurtado left the public sector and started his own computing and Internet solutions company. He is frequently called upon to provide expert witness testimony in EMS and Emergency Medical Dispatch related lawsuits.

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