

The MPDS and Medical-Legal Danger Zones

• Scott A. Hauer

Dr. Clawson's Medical Priority Dispatch System (MPDS) has been developed and refined over the last twelve years to, in a nutshell, provide two basic functions. First, to assist callers with *pre-arrival instructions* prior to pre-hospital care providers arriving at the scene; and second, to help the dispatcher determine *appropriate levels and configurations of response* based upon the answers they receive to certain medically approved key questions.

Many individuals and EMS agencies have expressed certain concerns surrounding the legal implications of implementing the MPDS and of providing pre-arrival instructions. Unfortunately, we do live in a very litigious society, and these concerns must warrant an explanation.

According to a recent survey (JEMS 1989), 61% of all services providing medical dispatch are using some sort of a pre-arrival system. Of that 61%, 69% are ad-libbing and 31% are using protocols, a much safer way to operate from a legal standpoint. Of the dispatchers providing pre-arrival instructions, 34.2% are EMT's, 5.4% are paramedics, 22.5% are EMDs, and an astonishing 37.8% have no training at all. In our experience, we have seen those dispatch centers who have EMD trained personnel and are using a protocol system, incur much less attention from the legal

community than those without. Some of the most common questions and misconceptions regarding the legal hazards of providing such an additional level of service include:

1. *Are we practicing medicine over the phone?*
2. *Can we be found negligent should a patient die?*
3. *What if we're too busy to give pre-arrival instructions?*
4. *Do we have a duty to provide this additional service?*
5. *Is this call screening?*
6. *How can we protect ourselves from litigation?*

ably concerned. Those who wish additional information on these subjects, or have other related questions, should feel free to contact either myself or one of the NAEMD's Regional Instructors.

To begin with, **are we practicing medicine over the phone?** The answer is clearly no. Pre-arrival instructions (or post-dispatch suggestions) are designed to do three things: to provide immediate assistance through the caller when certain emergency conditions are present; to protect the patient and caller from potential hazards; and to protect the patient from well meaning bystanders who may unknowingly provide incorrect treatment. The MPDS does not pre-

scribe any medical procedure that would cause harm or injury to the patient or place the dispatcher outside their realm of expertise. The instructions and advice consist of simple first aid "do's and don'ts." By using appropriate key questions, the dispatcher is able to identify the problem generally (*not* diagnose), identify the presence of "priority symptoms" and respond to those symptoms with simple, non-invasive, first aid procedures.

In answer to the negligence question, I will quote James O. Page, who stated that "A patient who is breathless and pulseless can not be made worse, therefore, there can be no negligence for a good faith attempt that fails or leaves a person better off." In time-life priority situations such as cardiac arrest, choking, and child-birth cases, the dispatcher us-

ing the MPDS stays on the phone with the caller and instructs or coaches them to do something *positive* for the patient during the response time lag that proves fatal in so many cases. The alternative is

THE DISPATCH DANGER ZONES

1. **No send policies.**
2. **Delayed responses.**
3. **More than one call for EMS.**
4. **Omission of pre-arrival instructions.**
5. **Dispatch Diagnosis.**
6. **Failure to follow established protocols.**
7. **No protocols to follow.**
8. **Failure to verify address and call back number.**
9. **"Let me talk to the patient."**
10. **Problems at shift change.**
11. **Attitude problems.**
12. **Pre-conceived notions and imposed negative personal impressions.**
13. **Mistranslation and/or misinterpretation of chief complaint (not seeing the forest through the trees)**

There will be extensive responses to these issues at the Conference this October, here I will attempt to only briefly answer these questions and allay any misconceptions of those who are justifi-

for the caller to stand by and watch the patient needlessly die. Even is the caller accidentally breaks a rib or bruises the patient's abdomen while administering CPR, for example, the only other option would be death. Can the dispatcher be held liable? No.

But what if we're too busy? This is also a valid question. Time has shown, however, that the majority of instructions relayed by the dispatcher using the MPDS can be done *briefly* and the caller told to call back if other problems arise. We often have cases come in that require no instructions at all. The amount of time spent on the phone by dispatchers does *not* increase as result of using the MPDS, due to the fact that the dispatchers are trained to follow a *protocol*, rather than make up questions every time they answer the phone. Obviously, here are times when the dispatch office is swamped with calls or when manpower is taxed in the communications center. The question has been asked whether we can be held liable for not providing pre-arrival instructions to all callers when there is a rash of alarms or calls for request. In answer to this question, William Prosser (*ref: Law of Torts, Third Ed.*) has stated that the courts will find that in times of emergency, a person is not held to the same standard as one who is faced with no such emergency, based on a principle of reasonableness.

The question of our **duty** is a frequent one. We believe that we do have a duty to provide this additional level of care based upon a number of factors. Duty is defined as the responsibility to act or perform in a similar fashion as another similarly trained dispatcher would under the same or similar circumstances. "Changing social conditions lead constantly to the recognition of new duties" (*ref: Prosser, Law of Torts, Third Ed.*). We have been witnessing a changing social condition in the field of EMD for several years. EMS is a changing and dynamic industry and according to a

number of nationally recognized entities and expert opinions, the duties of the EMD have also been changing.

In studying past law suits that have been filed against dispatch agencies, we have identified a number of common factors. These we call the "**dispatch danger zones**" and they are discussed in detail during the National Academy's EMD certification course. They include **call screening** or no send policies, mechanisms by which large municipalities screen calls for validity and the dispatcher is left to decide whether to send help or not. We have seen that dispatch diagnosis is tantamount to dispatch malpractice and should not be used. The impetus for this type of program comes from the need to reserve valuable resources for those who actually need it. We have found that through proper questioning, based upon medically approved protocols, the dispatcher can confidently make a decision on who goes, how many go, how they go, and when they go. This is one of the emphasis' of medical priority dispatching: sending the right thing at the right time in the right way. *Call prioritization is not to be confused with call screening.* The point with the MPDS is that everyone gets appropriate on-scene help based on their chief complaint and other symptoms present. The protocols have enjoyed over 10 years of refining and field testing. During that time we know of no litigation that has been brought against an agency that is correctly using the system. There is no other comparable system anywhere.

Finally, I will address the question of **how to protect ourselves from litigation**. First, and most obviously, we must **avoid the dispatch danger zones**. By providing proper training for EMD personnel, this can be achieved. Knowing why the dispatchers should do something gives them the power to do it. Conversely, knowing why not to do something empowers you with the abil-

ity to avoid behavior that may put both dispatcher and patient at risk.

Having strong **medical control** assists the dispatch agency in providing a safe environment for the health of the system and to nurture and maintain safe practitioners. **Proper record keeping** is a must to thwart unfounded litigation, as is **proper supervision and team building** to establish a loyal labor force. Other recommendations from the National Academy include the establishment of a **risk management and quality assurance program** to ensure the proper application of the MPDS.

The National Academy is committed to assist dispatchers and their agencies through its conferences, seminars, EMD training, testing, and National Certification programs. Fellows of the Academy are also available for on-site EMD systems evaluation, consultation, and MPDS implementation. ■

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