Medical Miranda
Extending Priority Dispatching

The "Medical Miranda" card has resulted in better initial information and fewer relays of questions between police and EMS.

by Jeff Clawson, MD

"Dispatch, Patrol Car 15. Call city fire and have them send their paramedics over here right away." How do most paramedic providers respond? They send over the paramedics, of course. And why not? The police ordered it, didn't they? But how did they assess the need for paramedics? If this is a trauma case, what will ALS personnel add to the victim's definitive care? Do they really mean they need advanced life support?

Since the advent of dispatch priority protocols, the practice of sending paramedics on request is finally disappearing. It makes sense. Often law enforcement officers don't clearly understand that paramedics aren't just better EMTs, but that they offer specific additional treatment adjuncts. That they add little to the treatment of most non-critical trauma is not usually perceived.

We have instructed our EMTs that a request for "paramedics" means that "emergency medical help is needed." Tell us what you've got and we'll apply dispatch protocol and send the appropriate medical personnel. Unless every officer carries a set of 32 priority cards in his pocket, he can't possibly request, on a consistent basis, the correct personnel and response configuration in a multi-unit, tiered response system. Yet the "ham-on-rye" practice of "ordering" paramedics happens every day in every part of North America.

In case you're wondering, this is not, in any way, an ill-thought out slap at "police mentality." Let me illustrate. Suppose police arrive first at the scene of a car vs. tree accident in which it is obvious that a woman is pinned in the wreckage. The officer immediately radios his dispatcher to request the fire department to "send the paramedics." The officer attends to the victim while awaiting the arrival of a nearby paramedic unit. As it pulls up a few minutes later, the officer yells, "She's trapped in the car. Bring your jaws-of-life." Everything's okay so far you say? Wrong! Ask the bewildered paramedics who reply, "We don't have the jaws. They're on Rescue-12 near the freeway entrance four miles from here."

Access to the victim is delayed an additional seven minutes.

To the officer in this case, "paramedics" meant "extrication" - not advanced life support. Had the officer indicated to dispatch what the problem was, Rescue-12 would have been initially dispatched to extricate. Even if every unit has heavy extrication capability, how many police officers were told at morning report that your jaws were down for repair or that your MAST suit hadn't been returned yet by LifeFlight. This "what if" case happened to us and it helped to make a very important point with our police administration who likewise want the best, most efficient care for their citizens.

From our experience in Salt Lake City, we can suggest some relatively simple solutions. If law enforcement doesn't understand new necessities and capabilities based on our recent evolution in medical dispatching they can't possibly be expected to mysteriously adapt to our needs. We have to rationally explain our improved methods to them. And if I know the caliber and professionalism of the majority of law enforcement agencies, they'll come through. But not until you take the effort to meet, discuss, and plan with them - not just sit back and complain about the "damn cops."

Our meeting with the city police administration was, to their credit, generated by them to ask about what they referred to, not comically, as our "20 questions game." During that meeting, we described the priority card system and the necessity to ask a minimal number of questions to ascertain the appropriate response, whether paramedic/engine, EMT/engine, private BLS ambulance, or combinations of the above. It wasn't surprising to us that the "damn cops" understood the first time. They didn't squirm, change the subject, or call "King's X." They merely stated, "What specifically do you want our scene officers to relay to you on each case?"

Well, what would you want dispatch to know if the answers to a generic set of questions could be relayed from each first arriving scene officer? Simple, start with the "Four Commandments" of medical dispatch: 1) chief complaint, 2) age [approximate], 3) status of consciousness, 4) status of breathing. "Anything else?", the police major asked. Yes! If the case is medical, does the victim have chest pain? If the case is trauma, is uncontrollable hemorrhage present? "No problem," he replied, "Is that all?" Well if any additional information or special circumstances are appropriate or apparent, such as the need to respond red-light-and-siren, relay them to us. End of meeting.

To accomplish this, we decided upon a two-part approach. First

Jeff J. Clawson, MD, full-time fire surgeon for the Salt Lake City Fire Department and medical advisor for the Salt Lake County Fire Department, originally devised the concept of Medical Priority Dispatching in 1977. Those interested in obtaining additional information or parts of the Medical Dispatch Priority Card System, the Utah EMT training program manual, or pre-arrival instruction example cassette, should contact the author at the Salt Lake City Fire Department, 159 East 100 South, Salt Lake City, Utah 84111. All items requested will be provided for cost and postage.

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The following letter was written by Darrell Willis, Deputy Chief of Prescott Fire Department, Prescott Arizona, to *JEMS magazine*, July 1988, regarding the effectiveness of Medical Priority Dispatch.

**Dispatch Program:**

The results of our new EMD program by Dr. Jeff Clawson may be of interest to any of your readers who may be thinking of implementing one. Our mountain community of Prescott, Ariz., has 25,000 people. The fire department, dispatched by police communications, has four stations, 55 paid personnel and 21 reserves, and operates two ACLS engine companies, two BLS engine companies and one BLS truck company. In 1987, the department responded to 2,220 incidents.

Dr. Clawson’s Emergency Medical Dispatch Program is designed to meet three goals, and in just two months we have met all three. The first goal — providing medical self-help instructions to third party callers — has been successfully used three times on cardiac arrests. Before, dispatchers did not give directions.

Goal two — providing accurate, pertinent medical information to responding units — has also been met. Instead of dispatching a call for an “ill person,” dispatchers now provide a minimum of the chief complaint, status of consciousness and breathing, and the age of the patient. In most cases, past medical history and current medications are also relayed to responding units. Dispatchers also feel more a part of the system, given the greater understanding of the incidents.

By far, the third goal — reducing red-light-and-siren responses to minor medical incidents — has been the most obvious improvement in our service. We have reduced Code 3 responses by 35 percent, and now on minor medical calls, the closest BLS engine is dispatched without ALS backup. If the captain arrives on the scene and determines that paramedics are required, he will have them dispatched. We have had 325 medical incidents during this period, and no patients have had a delay of necessary attention.

The staff at the Prescott Fire Department feels the reduction of Code 3 responses increases the safety of both citizens and personnel, and decreases the city’s liability. We believe with the statistics that are reported each year on fire-service injuries and fatalities, this is one pro-active way to reduce risk to our personnel.

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_Darrell Willis, Deputy Chief_  
Prescott Fire Department  
Prescott, Arizona_