From the President’s Desk:

• Jeff J. Clawson, M.D.
President, NAEMD

“Can’t You Tell Me What to Do?!”

Recently several individuals and governmental agencies have approached the NAEMD and me personally with several common questions about the legal ramifications associated with not implementing a Medical Priority Dispatch System. In response to the majority of these questions, I can offer the following synopsis of what is fast becoming an absolute avalanche of medical-legal questions, to offer the following synopsis of what is fast becoming an absolute avalanche of medical-legal questions, and an eleven point quality assurance program, the lawsuits filed against them totaled over $50,000,000 in asking damages.

Liability cases range from small systems to the biggest, and have occurred in every part the United States. One reason for the lack of general public information on these cases is that once the defendant (usually a governmental agency or private service) deposes the medical dispatch expert and sees the extent of proof regarding the national standard of care and practice, they often settle forthwith. Little case law is therefore actually generated, since, only after a verdict is rendered can the case be appealed, which is the process that creates case law precedent. There are three general topics of appropriate concern in the area of dispatch law and risks. These are (1) provision of pre-arrival instructions, (2) the practice of dispatch prioritization, and (3) red-light-and-siren use.

In the last 13 years, there has never been a case, successful or otherwise, against a dispatch center or agency that used the MPDS.”

When pre-arrival instructions were first formulated in Phoenix and Salt Lake City in the 1970s, they were considered a dangerous novelty. Somehow, the remarkable success that these and other agencies had in providing them was magically discounted. While people fear that they might be sued for offering telephone help, the time has come when the failure to give pre-arrival instructions is resulting in lawsuit after lawsuit.

I am aware of four (4) suits currently active where PAI omission is the core issue of the suit. In a few others, it is an associated issue. In one case, the mother of a deceased child was quoted by her attorney in the intent-to-file-suit letter against a small agency in Southern California. The letter stated, “She knew the dispatcher should have told her what to do, because she had seen it on TV.”

In a drowning case in south Florida, a 13 year old sister of the victim, plucked the lifeless body of this 18 month old girl from a swimming pool, raced to the phone, called 9-1-1, and was told to stay on the line, as paramedics were being sent. After asking two or three times what was happening without a satisfactory answer, finally pleaded with the dispatcher, “Can’t you tell me what to do?!” She was told, “just stay on the line.” No instructions were ever given, the girl was eventually partially resuscitated, lived a year as a complete vegetable, and died. By the way, the 13 year old’s favorite TV show was Rescue 911. Does the fact the entire nation gets an in-service lesson on standard of EMD care continue on page 2
every Tuesday night on CBS cause a bit of concern in light of these tragic events? It should.

The second area of concern is the lack of standardized dispatch decision making with regards to prioritization. When there exists a proven, medically approved protocol process, that has been used in over 40 million dispatches without a lawsuit, it borders on foolhardy to continue the traditional type of dispatch process now referred to tongue-in-cheek as "Dodge City dispatching". With all due respect to the modern Dodge City, Kansas, the old Dodge City of the wild west was a lawless place where people did what they wanted to do, whenever they wanted to do it, to whomever they wanted to do it to. This in essence describes dispatchers that "fly by the seat of their pants" and "reinvent the wheel every time the phone rings". A standard, well designed, reputable medical protocol system produced and maintained by a dedicated, stable organization, gives EMDs and their employers, a clear standard to rely on. This objective, recognized standard would provide a sound basis for defense in any lawsuit so long as it is followed.

My third concern, is that of unnecessary red-light-and-siren use. There are literally thousands of emergency medical vehicle accidents every year in this country. And the sobering fact of the matter is, most of them are preventable. If appropriate prioritization is followed as designed, many cases can be safely sent "COLD" vs. "HOT". In March of 1989, the City of Los Angeles began sending 25% of their BLS responses "COLD". And they have not received a single formal complaint to date that I am aware of. This area will be a major driving force for a more rational dispatch response mode process in the 1990s and therefore a sound, well structured MPDS.

What does this all mean? It's actually quite straightforward. Organization is better than disorganization. Training is better than no training. And you get what you pay for... otherwise you end up "paying" for what you got. This knowledge has made me a true believer in the medical priority system when implemented in its comprehensive form. Of course I'm biased. But then please realize that I receive information about, or am retained as an expert witness in, one dispatch-related lawsuit literally every other week.

It has always been the mission of public safety agencies to protect the lives of their citizens. Without question, Medical Priority Dispatching continues that fine tradition.

For more information call Medical Priority Consultants: 1-800-363-9127