



## Beyond the Crossroads

**T**he 2006 Institute of Medicine report *Emergency Medical Services at the Crossroads* portrayed a nationwide prehospital care system lacking not only uniform training and standards but coordination between ambulance providers, dispatch centers, and hospital emergency departments. After describing significant advances in the 1970s, the report noted decades of little or no progress when federal funding evaporated. Yet, during that time, technology continued to advance to the point where we can now transmit voice, video, vital signs, and ECGs from the backs of moving ambulances directly to receiving hospital emergency departments (EDs) or cardiac catheterization laboratories. Moreover, by using commonly available GPS devices, we can locate and track any ambulance in a regional system as it responds to a call and, afterward, as it transports a patient to a designated ED. We can then provide that ED with information about the patient, the nature of the medical problem, and the estimated time of arrival. But, except in cases of life-threatening trauma and medical emergencies, we don't.

Imagine an air traffic control system that manages and tracks departing flights only, leaving arriving flights to the pilots and airport personnel. Yet, this is how we approach prehospital care today. Among the reasons cited for the current state of

affairs is the lack of federal funding or uniform federal oversight, especially the lack of a single lead agency to supervise prehospital care. More importantly, some emergency physicians and nurses may feel that routine notifications are not necessary, maintaining that they are trained to care for any patient with any problem at any time and without prior notice. But even if this is true, it doesn't mean that notification is not desirable. Some nurses are concerned that in busy EDs, frequent notifications will interfere with other duties, which only begs the question: in such EDs, shouldn't a nurse be assigned exclusively to manage and triage approaching ambulances, if necessary?

Other problems that must be addressed before a comprehensive prehospital dispatch-control system can be instituted include disparities in size and nature of EDs within a region, patient preferences or demands for specific ED destinations, and appropriate timing and nature of "handoffs" from regional 911 ambulance dispatchers to either hospital-based dispatchers, when available, or designated ED nurses. And then there are the ambulances—municipal (911, "Fire-Rescue," EMS), hospital-based, private, and volunteer, typically operating simultaneously in the same regions. None of these issues are insurmountable, including the last. After all, air traffic control also handles private planes along with commercial carriers

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using the same airports and skies.

The real question is, what would be gained by having such a comprehensive prehospital dispatch-control system? Imagine the following scenario: a stable elderly patient who suffered a stroke eight hours earlier arrives by private ambulance at a busy ED and is assigned by the charge nurse to the last available room—"Resuscitation One." Two minutes later, a 911 ambulance brings a middle-aged male patient requiring resuscitative interventions following an ST-elevation myocardial infarction. Five minutes after that, two seriously injured patients from a motor vehicle accident are brought in by two other ambulances. Faced with such a nightmarish confluence of emergencies, wouldn't it be better to know about these patients before each ambulance arrived, so that more appropriate room assignments and patient movements could be made in anticipation, and special equipment, consultants, and specialty teams requested prior to the patients' arrivals?

The goal should be a seamless transition from prehospital to ED care, and at present we are inexcusably behind in providing it. □