To: All Providers

From: Roger M. Stone, M.D., M.S.

RE: Educational Insta Fax, #5 in a series (2003)

Title: What about the Science of Treating and Releasing?

How many times have we heard feedback from colleagues or thought to ourselves about why we in EMS "have to" take all people to the hospital without discretion?

This begs the question about the feasibility of provider based refusals... Yes, it has been tried in various places, but I am not sure it has lead to near as much success as it has to difficulty. This has been an area of interest for EMS researchers through the years, often related to the topic of "expanded practice" or "super paramedic". Moreover, we do use some discretion with obvious priority 4 or mildly injured patients.

Given the science out there, what info or guidance does the literature actually provide with respect to this question? I will share with you an excellent lecture given in January 2003 at the NAEMSP Annual Symposium in frigid Panama City Beach, Florida. David Cone, MD, extensively published EMS Physician and Medical Director from Yale/New Haven gave a literature synopsis for colleagues. There were 10 studies, including one from here in Maryland at Baltimore City/ UMBC/UMB.

1) If medics are allowed to "wing it" without strict protocols guiding there decision-making, the under triage rate for transporting to hospitals could be as high as 40%. This means that if we "guess" wether given patients need the services of medical attention, we will be wrong a boatload of times.

2) In studies where medics were given strict protocols to guide them into deciding which patients may be less serious, many things were discovered. Firstly, the under-triage rates using these criteria were variable, but the absolute best rate of under triage was 15%. Again, this means that if we tried to implement such criteria in a system our size, we'd be leaving on the scene hundreds of patients who desperately need ED care. Secondly, those studies showed that we cannot use criteria to "account for or exclude" the preponderance of ED diagnoses, such as most of the high risk issues.

3) The study from Maryland, which included Dr. Bissell from UMBC, Howard County's Medical Director Dr. Seaman, and our own MIEMSS executive director Bob Bass as authors, was conducted to study the feasibility of expanded scope of practice. In it, they followed EMS patients through to their hospital stay, and found that Baltimore City Paramedics confronted over 2,000 different ICD-9 diagnoses in the 911 emergency populations. The majority of these had clinical significance if not brought to medical attention. The conclusion was that the advantage of expanded training short of a physician’s evaluation before treating and releasing on the scene may be smothered in the

shear numbers of illnesses that might be present. The degree of additional education for the "super paramedic" may not be as feasible as once thought.

4) A Seattle study of alternative destinations rather than EDs claimed that it had found a safe program to use. It was flawed in that only about 80 patients out of the 480 that their own criteria would have been "sent" to the urgent care center actually agreed to go, and the centers were empowered with the right to refuse over radio. The 400 other patients who would have gone if the study had theoretically worked but instead went to the ED were never followed up to see what they wound up having. This means we'll never know how many of these patients the medics would have harmed if they hadn't gone to the ED.

Conclusions were that EMS physicians are desperately looking for safe ways to empower medics with decision-making skills, but there is nothing out there that supports a widespread treat and release program by the Para medicine provider. Please keep this in mind next time you wonder why we do what we do.