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Dispatching Debate Develops

I read with considerable interest the "opposing viewpoint" by Jack Stout (May 1984) regarding his interpretation of priority dispatch, his philosophy plugging an all-ALS system, and his prediction of the demise of tiered response. Unfortunately, I must say that his definition of priority dispatch as a method of stacking calls is novel, but not accurate. The term means to assign various levels of available response not only with regards to ALS vs. BLS needs, but to select the rapidity of response necessary, whether red-light-and-siren or routine mode. I think that I can safely make this claim since I originated the phrase.

With regards to all-ALS transporting systems, I can only say that this view is not widely accepted or practical in maximizing already available resources found in the ubiquitous fire department. The spread of paramedic/engine programs is only one example of growth in a completely opposite direction which at least points to the internalization and acceptance of medical programs into traditional fire department structure.

Finally, prophesying the death of tiered response—are you kidding? The incredible spread of EMS training and priority dispatch screening has finally given order to tiered response and actually insured its survival. Just as having a neurosurgeon evaluate every kid with a goose egg is inappropriate, so is the non-tiered all-ALS response concept. Reality-based ideas will prevail. Paraphrasing what Shepard and St. John stated in 1983, new programs in call screening, in priority dispatch and tiered response will allow the EMS manager to maximize the efficient use of already available human and material resources in the provision of quality, safe, and effective patient care.

Jeff J. Clawson, MD
Fire Surgeon
Salt Lake City, Utah

Mr. Stout Replies: I have admired Dr. Clawson's work and respect his views. In the context of conventional assumptions about the underlying economic structure of the prehospital care industry, the logic of tiered systems to conserve limited ALS resources is unassailable. Dr. Clawson's work has done much to limit the dangers of multi-tiered system dispatching, and for that he deserves recognition.

As to the term "priority dispatching," I am forced to suggest that it is not a term of art, and might well take on different meanings in different contexts. Even in our own all-ALS systems, we "prioritize calls" for various dispatch-related purposes, but since we have no less-capable ambulances, we do not use this process to screen calls.

Once born, a useful concept always begins to evolve, well outside the control of its originator. We are bound to use our own experience, training, and judgment to alter, perhaps even improve upon, what we have learned. The context will change, even the definition may change.

The issue, though, is those "conventional economic assumptions" that provide the foundation for multi-tiered systems. In the long run (25 to 30 years in this fast-changing industry), multi-tiered systems will give way to fully professionalized systems. *Today, we squander about $2 billion annually in the production of BLS transport services, and then argue that we must screen calls because of limited ALS production capacity.*

Government ALS providers complain of limited financial resources while billing at token rates set at a fraction of full production costs. They are worried about the department's image. And they often refuse to bolster revenues by performing nonemergency transfer work because such work is somehow beneath them. Sure, they argue that they must remain available for emergency work, but the argument doesn't hold water. Even in really high cost systems, the net revenues from one transfer run will pay the marginal costs of three or four times the unit hours absorbed in running the transfer call.

I agree that we don't need to have a "neurosurgeon evaluate every kid with a goose egg." The analogy, though, is stretched far beyond its limits when we're talking about a paramedic being over-qualified to transport sick people to and from health care facilities under nonemergency conditions. In most states, you can become a paramedic faster than you can become a barber, a beautician, or a licensed electrician.

The abilities of a paramedic are truly valuable, but the investment in training seems extensive only in

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relation to that of a basic EMT—not compared with most skilled and semiskilled trades and professions. The career paramedic does not benefit by sharing an industry with far less qualified workers. One day they will figure this out and become the most vocal advocates of fully professionalized systems.

My perspective may well be in error, but like Dr. Clawson's admittedly persuasive views, the complex argument in favor of a fully professionalized prehospital care industry will be a force to contend with over the years to come. Even to do battle with such an idea, it must be understood—not dismissed.

Jack L. Stout
Beaufort, North Carolina

Interpretation Only Partially Correct

A brief piece in Tom Vines' "Around the Nation" column (March 1984) states that "under current New York state regulations, anyone who demands an ambulance must be transported to a hospital, whether or not ambulance attendants consider it necessary." This statement is only partially correct.

First, the requirement is a statute, not a regulation and can therefore be changed only by the state legislature. Second, the requirement applies only to those cases for which an ambulance has been sent, permitting a dispatcher to screen out calls for which an ambulance is clearly inappropriate. Third, the requirement is applicable only to any service "supported wholly or partly at public expense, or which is wholly or partly under the care, management, or control of the public authorities." This law is clearly applicable to the New York City Health and Hospitals Corporation and other municipally operated services, but it is not certain whether it is applicable to commercial and volunteer services.

Michael Gilbertson, Director
EMS Development Program
Albany, New York

More on Rx for Medical Control

In response to Mr. Stout's comments (Letters, June 1984), I made several assumptions in writing that article ("Rx for Medical Control," April 1984 *jems*). One of them was that the prospective phase developed and promoted adequate and well defined prehospital protocols. Also, in promoting remedial training, I was assuming that the same mechanisms that establish the preplanned, ongoing in-service training would also address remedial training problems.

I disagree with Mr. Stout's "indicator" and method of problem detection. If medics were left to police themselves, there eventually would be major problems.

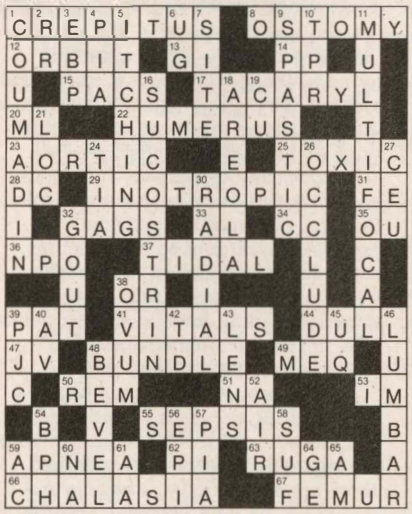
I do agree that the "exception" is often a great source of information. I'm sure we would also agree that we need to learn from our mistakes and find ways to make improvements so that a similar problem does not reoccur.

E. Michael Latessa, Chief, EMS
St. Louis, Missouri

Correction

The "Innovations" article on "The Sked" (May 1984) included an incorrect phone number for contacting the manufacturer. The correct phone number for SKEDCO is 503/242-0085. Our apologies to SKEDCO.

We welcome readers' comments. Write to ***jems****, P.O. Box 1026, Solana Beach, CA 92075.*



"Puzzler" is on page 24.