A Road *in the* Woods

By S. CHRISTOPHER SUPRUN JR.

Lines 14 and 15 on Page 4 of the *National EMS Scope of Practice Model* draft are perhaps the most telling of any I have recently read: "The United States EMS System faces many challenges as it transitions to a more community-based health management system ...." Read those lines and you may reach the same crossroads Robert Frost did when he came upon the two diverging roads in the snowy, yellow wood. EMS is at a similar crossroads; the direction we take in the next few years will be crucial.

EMS as a profession needs to make a diagnosis of its current state and decide on a prognosis for its future. If we look at our colleagues in the fire and policing communities, we will see that although they still respond to emergencies, they also have taken on significant responsibility in prevention efforts. While firefighters are working on preplanning and inspections and police are present in the schools and communities doing preventive policing, where is EMS?

How many people know Mrs. Smith, who lives alone three blocks from the station and seems to call every second week? Her complaint is dizziness or malaise, or something else medically nondescript enough to make it possible that there is something going on with her. How often does she—or someone like her—wait in her favorite chair or at the door with bags packed? How hard is it to assess this patient, as she quickly wants to turn the conversation to how her children never call her? Probably every department in the country has a Mrs. Smith in its primary response area.

These patients aren't the gory traumas or the successful resuscitations that EMS providers hope for, but they are important opportunities to make a difference in people's lives. EMS needs to embrace preventive paramedicine as a means to work with other public service agencies to identify needs throughout the community. A quick visit once a week to these people to do some vitals not only provides a baseline for further treatment but could aso identify other problems that require referral to social services or another community-based group that might help Mrs. Smith with nutritional needs, household hygiene, and so forth.

Can paramedics or advanced practice paramedics be trained to use an otoscope, pull the ear back, find a mild fever, and see the other associated symptoms that could tell them that the child they are examining has an ear infection? If so, why shouldn't they be able to dispense a voucher for the local pharmacy so the patient's parents could pick up the antibiotic de jour with follow-up instructions should the child's condition change for the worse?

No, this isn't the emergency care we all signed up for, but it does serve an important purpose to the community. If it helps prevent a transport to the community emergency room for a "loneliness" call or an ear infection, then we have helped the health care system in a small but very measurable way. It saves time and effort in the ER and could probably be reimbursed by insurance at some level. Is mopping the bay floor really that much more refreshing and rewarding than spending 15 minutes with other human beings, making sure they are okay and reassuring them about conditions they might suffer?

I know that from a staffing perspective many will complain that we don't have the time to do any of that, but it's not really true. If these visits take the 15 or 20 minutes they should, you could complete maybe five of them in the time it would take to run one full response call: responding to a location, assessing and packaging the patient, transporting to the local ER, and then completing transfer, documentation, and clean-up.

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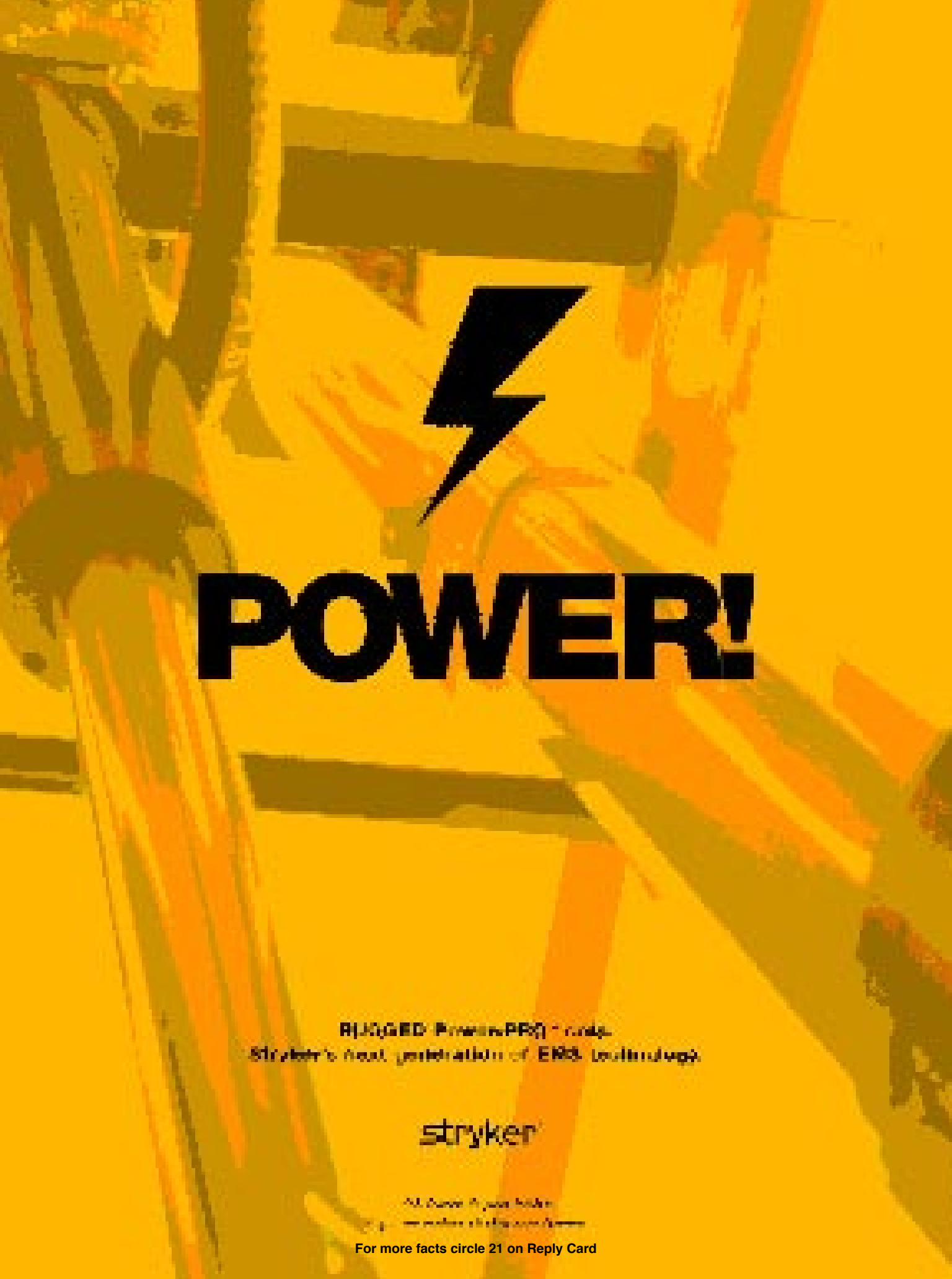
Another argument against increased use of paramedics may come from some doctors who say this gives paramedics "prescriptive power." What is it we have now when we push 50 percent dextrose via IV when x, y, and z conditions are met? We have prescriptive power now in the form of standing orders and protocols. What is interesting is the number of physicians who will jump on board with giving paramedics the ability to induce patients into unconsciousness and medical paralysis, but not the ability to help the kid down the street who is tugging at his ear or the elderly woman who needs 15 minutes of quality time with another human instead of 12 hours of ER waiting room time.

No, we aren't doctors, but we can deliver quality medical care as clinicians, not technicians. Many paramedics complain that they are simply treated as ambulance drivers who can do some skills. The advice I often give is that if you want to change the perception, you have to change the profession. Public perception runs the gamut from the typical "you're just an ambulance driver" to the belief that we are, in fact. physicians. In one study published by the *American Journal of Emergency Medicine*, 15 percent of respondents thought "paramedics were ED physicians." Although that number may not be huge, it is significant; were I to add 15 percent to your paycheck, you would probably notice.

But what's really important about that number is that it is one of the few quantifiable measures of the consumer's view of EMS we have. We need to look at the consumer of our care. We would never assume a patient needs amiodarone, epinephrine, or solu-medrol until we got on-scene and assessed the patient. Yet our discussions about the future of EMS generally include doctors, nurses, medics, firefighters, even city administrators. We are talking about how to treat the patient with everyone except the patient.

A separate but related area of necessary improvements in EMS concerns education. It is shocking to see the *Scope of Practice* draft talking about reductions in training. In the past 10 years, medicine has gotten more difficult and more complex, not less. Many EMS providers clamor for new skills or treatment modalities; how can anyone say we need less education to do more skills? Many EMS providers find it difficult to pass ACLS after coming out of EMT-Intermediate school. What will happen if we further lower their educational structure to try to cram more information into it? More than that, our patient population is becoming more educated through online medical diagnosis and advice sites, cable television, and



the neighborhood library. We need to keep up with them.

"New paramedic students seem to have little biological knowledge," said Chuck Skinner, director of education for Red River Medical Institute and a North-Central Texas flight paramedic. "They don't understand pharmacologic effects of basic drugs such as aspirin and lidocaine, much less heparin."

Similar complaints can be found everywhere, as we try to teach to the test instead of teaching critical thinking skills. I have taught enough ACLS classes to know that everyone wants to know "what's on the test," not what's in the book. As students remove the shrink-wrap from a textbook they bought out of obligation rather than aspiration, one gets the very real feeling that they see themselves stuck in a "going through the motions" routine. This is critically unhealthy. EMS needs to find itself aggressively attacking the educational indifference many of our providers feel.

Although it may be painful, EMS needs to start addressing the health care needs of our communities on a proactive basis. We need to start by deciding that what we learned five or 10 years ago is not enough. We must learn more and become better prepared for the everyday diseases we face, using continuing education as a positive source of new information, and not another four-hour session that we have to go through every month.

We must become willing to work with parts of our community that may not be the most desirable. They may be the parts of the community that are, in fact, un-fun and require actual work. However, being seen and available to the community is honestly something we've been attempting to do for years to build up positive PR. Many fire departments will provide a fire engine or an ambulance for fairs, community events, and in some cases, children's birthday parties. Isn't it as important to check in on the frail and vulnerable in our community as it is to go to a kid's birthday party?

The EMS industry needs to look at its future carefully and decide whether we want to be ambulance drivers or medical professionals. Those decisions will ultimately affect our salary structure, the availability of community health care, and the perception of us that the public holds. Although the extra hours of classroom and lab training, the additional non-emergent care, and the customer service training will place some constraint on staffing levels, it will let us be better health care providers to the community.

When the decisions are made that turn us left or right in the forest, I hope we will choose the road less traveled by. It can make all the difference in the world.