Docket No. SA-530

Exhibit No. 5-K

NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C.

We Have a Problem

(11 pages)

JEMS.com

Column

We need to educate the public and politicians about what we really do and how we do it. (Photo Mark C. Ide)

Houston, We Have a Problem

Bryan E. Bledsoe, DO, FACEP
Another Perspective
2008 Oct 2

The media has paid more attention to EMS during the past few months. Unfortunately, it hasn't been the sort of attention we need. Certainly, the recent cluster of medical helicopter crashes has made the national and international news. Then, there have been the stories of stolen drugs, misappropriation of finances, sexual assaults, and even theft from patients. If it weren't for bad luck, we would have no luck at all.

Thus, when faced with issues such as these, it's time to become introspective and re-evaluate some of our practices. Most importantly, we have to educate the public and the politicians about what we really do, what we really can do and what we really can't do. The television show "Emergency!" was shot on a back lot at Universal Studios in Hollywood, and, unfortunately, many people believe in the message from Hollywood like it was the divine, inspired word of some deity. One of our jobs, then, is to show that Hollywood is far removed from reality (or even common sense).

First, let's make politicians understand that response times for EMS are not as critical as once thought. Recently, in the "Austin American Statesman," there was concern that Austin, Texas, might cut an ambulance and an academy class because of a budget shortfall. The 2008 proposed budget for EMS in Austin is $44.1 million, making them one of the most well-funded EMS systems per capita in the United States. But people began screaming about response times despite the fact that there's no evidence that response times greater than four minutes make any significant differences in patient outcomes.(1-5)

Austin, which has a great EMS system, generally targets 10 minutes for most of their area. Granted, EMS responses less than four minutes are highly associated with improved outcomes from cardiac arrest. But there's no way an EMS system can expect to routinely achieve response times less than four minutes (except for the casinos in Las Vegas).(6) Attempting to meet benchmark response times (which are not rooted in scientific fact) place EMS and helicopter crews at risk. Everybody assumes out-of-hospital time makes a big difference. In reality, it makes little difference for most of our patients.

The "Baltimore Sun" and "The Capitol Gazette" (Annapolis, Md.) have been extremely critical of the highly regarded Maryland State Police (MSP) Medevac system. I've always touted the Maryland system as a model for helicopter EMS operations. But when it recently became necessary to replace Maryland's aging fleet of 12 Eurocopter Dauphins at a cost of over $130 million (at a minimum), the Maryland Institute of Emergency Medical Services System (MIEMSS) was called on the carpet because of poor maintenance and a lack of accountability in the MSP Aviation Division (although the MSP has had an impeccable safety record).

It turned out that in 2007, there were 4,383 helicopter transports by the MSP. Of these, 35% were discharged from the Shock Trauma Center in under 12 hours and another 11.5% were discharged in less than 24 hours. This would imply that these patients, for the most part, had minor injuries and did not require trauma center care. Further, the average helicopter transport time by the MSP is 14 minutes. It seems that considering the short 14-minute helicopter trip (including startup and shutdown), most patients would probably have arrived at the trauma center faster by ground ambulance. (MIEMSS now requires that patients less than 30 minutes from Shock Trauma be transported by ground.) Thus, virtually half of all patients transported by the MSP in 2007 had minor injuries.

Now, you always want to have some degree of over-triage to catch outliers. But a 50% over-triage rate is over the top. This is especially true when the annual operating budget for the MSP Aviation Division is approximately $20 million a year. That works out to approximately $10,000 per patient who was not discharged in less than 24 hours.

Additional light was shed on this issue when a report summarizing the scientific literature on helicopter trauma transport by Johns Hopkins University (requested by a member of the Maryland legislature) failed to show any overall benefit to patients from helicopter transport. But proponents stuck to the age-old mantra of meeting the "Golden Hour," even when the literature suggested that the Golden Hour wasn't based on scientific evidence.(7)

Now, there's no doubt trauma centers save lives. Anybody who does a great deal of the same thing usually gets good at it. I wouldn't take my Acura to a Chevrolet dealer because they're probably not good at working on Acuras. But specialty care centers (e.g., burn centers, trauma centers, spinal injury centers) are expensive to operate and we should ensure the right patients get there. Because prehospital personnel cannot fully detect all injuries in the field, we accept an over-triage rate. But nobody seems willing to say what the overall over-triage rate should be.

In a study we published in the "Journal of Trauma" in 2006, we found that two out of three patients transported from the scene in a helicopter had minor injuries by objective criteria. (8) Other studies have shown anywhere from 25–33% of patients transported by helicopter from a trauma scene are discharged within 24 hours. We need to refine our trauma triage criteria to reduce the usage of precious resources. Statistics can help.

One thing to recognize, though, is that mechanism of injury (MOI) is a poor predictor of injury. This has been beat into EMT and paramedic students for more than a decade. Like the "Golden Hour," there's little scientific support for MOI criteria (except for ejection from a vehicle). We need to eliminate MOI alone as criteria for calling a helicopter or taking a patient to a trauma center.(9) The American College of Surgeons needs to revisit trauma center usage criteria soon, especially because the helicopter usage criteria are widely based on the ACS criteria. Thought leaders in trauma surgery, such as Jeff Salomone, MD, are working hard at this.

As we take a closer look at our practices, we should note where EMS stands within the health-care picture. Health-care spending in the U.S. continues to rise. Total health-care spending in 2007 was $ 2.3 trillion, or $7,600 per person.(10) Stated another way, 16% of our gross domestic product (GDP) goes to health care. Despite spending more of our GDP on health care than any country in the world, the World Health Organization (WHO) ranks the U.S. 37th in health care quality.(11) EMS accounts for only a small part of the health-care dollar and should receive more. But we all have a duty to help lower health-care costs.

We can start by carefully using resources, such as trauma centers and medical helicopters. We can no longer accept emotional arguments and anecdotes when it comes to making important patient-care decisions. I was actually told by a group of paramedics last year (in a state that will remain nameless) that they often call a helicopter for patients after midnight because it takes an hour-and-a-half to get the patient to the hospital and then

return and they have to go to work at their part-time jobs the next day. Whether this was an issue of pay or laziness is unknown. But it shows that our system is broken, and we must work together to fix it.

JEMS.com Editor's note: Prior to publication, MSP Trooper 2 crashed, killing four people, bringing the number of deaths in helicopter EMS crashes to 24 for the 2008 calendar year. For an additional perspective on air medical transportation, read JEMS Editor-in-Chief A.J. Heightman's From the Editor in October JEMS. Also, click here to read news stories and watch a video about the investigation into the crash.

References

1. De Maio VJ, Stiell IG, Wells GA, Spaite DW; Ontario Prehospital Advanced Life Support Study Group: "Optimal defibrillation response intervals for maximum out-of-hospital cardiac arrest survival rates." Annals of Emergency Medicine. 42(2):242–250, 2003.
2. Pons PT, Markovchick VJ: "Eight minutes or less: Does the ambulance response time guideline impact trauma patient outcome?" Journal of Emergency Medicine. 23(1):43–48, 2002.
3. Blackwell TH, Kline J, Willis J, et al: "Lack of association between prehospital response times and patient outcomes." Prehospital Emergency Care. 11(1):115, 2007.
4. Vukmir RM, Sodium Bicarbonate Study Group: "The influence of urban, suburban, or rural locale on survival from refractory cardiac arrest." American Journal of Emergency Medicine. 22(2):90–93, 2004.
5. Turner J, O'Keefe C, Dixon S, et al: The Costs and Benefits of Changing Ambulance Response Time Performance Standards. Medical Care Research Unit School of Health and Related Research: University of Sheffield, 2006.
6. Valenzuela TD, Roe DJ, Nichol G, et al: "Outcomes of rapid defibrillation by security officers after cardiac arrests in casinos " New England Journal of Medicine. 343:1206–1209, 2000.
7. Lerner ED, Moscatti RM: "The Golden Hour: Scientific fact or medical 'urban legend'?" Academic Emergency Medicine. 8:758–760, 2001.
8. Bledsoe BE, Wesley AK, Eckstein M, et al: "Helicopter scene transport of trauma patients: A meta-analysis." Journal of Trauma. 60:1257–1266, 2006.
9. Boyle MJ, Smith EC, Archer F: "Is mechanism of injury alone a useful predictor of major trauma?" Injury. 39:986–992, 2008.
10. Poisal JA, Truffer C, Smith S; the National Health Expenditure Accounts Projections Team: "Health spending projections through 2016: Modest changes obscure Part D's impact." Health Affairs. 26(2): W242-253, 2007.
11. Photius Coutsoukis: "The World Health Organization's ranking of the world's health systems." **www.photius.com/rankings/healthranks.html**

- More articles by Dr. Bryan Bledsoe

Bryan E. Bledsoe

Dr. Bledsoe is an emergency physician in Texas. He can be contacted at bbledsoe@earthlink.net. Bledsoe also leads the Street Medicine Society, a group of physicians who got their start as EMS professionals. If you're a physician (MD, DO or equivalent) and have been involved in prehospital care, consider joining the SMS.

Learn more from Bryan Bledsoe at the EMS Today Conference & Expo, March 24–28 in Baltimore.

User Comments

Added Oct 3 2008 5:22PM

Spot on, Doc. As with every other significant dilemma facing EMS today, education is the only viable solution. EMS providers simply have to have the professional education necessary to make intelligent decisions in the field regarding patient care and transportation. Unfortunately, this is one situation where it cannot be fixed in the field. If you think about it, most HEMS transport requests come from rural and outlying areas. And those very same rural and outlying areas are the ones most often served by poorly educated and volunteer staffed agencies who fight any suggestion of elevated educational standards tooth and nail. To them, HEMS becomes a crutch. It becomes an excuse for not needing "all that book learnin'", since they're just going to call a bird for any patient that is outside of their comfort zone anyhow. Good luck convincing them to give that up. So really, if we cannot properly educate the gate-keepers in the rural communities, someone else is going to have to become the gate-keeper. If the HEMS community itself does not step up and self-regulate effectively, I'm afraid Big Brother will take the job for themselves. And when that happens, HEMS will not be happy with the results.

Rob
Mother
Added Oct 3 2008 6:45PM

Ok I respect that you used to be a street medic, but you aren't one anymore. Second of all if you want to blame someone, blame the lawyers. We call it "level one by lawyer". I would rather overtreat and fly my patient 60 miles to the nearest trauma center than to take a chance with litigation. I would expect the same from my comrades, especially if it's my family member. Thirdly,according to you we shouldn't go code three, use an air ambulance or obtain a CCEMT patch. I think you are so out of touch with street medicine it's unreal. I'm really tired of your preachy soap box lectures. Maybe you should stick with things you know, like air conditioned hospitals, and big fat MD paychecks. From now on I will be ignoring your articles. Besides we all know what they are about these days anyway. We got it. No code three? Check. No Air Ambulance? Check. No FPC or CCEMT? Check. Don't swipe the patients wallet. Check. No touching a patient in a inappropriate manner. Check and Check.
adhdcep911
Added Oct 3 2008 7:13PM

The fact that Dr. Bledsoe is asking for empirical data to justify many of our long cherished EMS beliefs should not be threatening. As health care dollars become scarce, all of medicine, including EMS is going to be asked to prove that what we do really has an effect on patient outcome. I too was saddened by the loss of the MAST suit, but if we are to evolve as a profession, we're going to have to face those hard questions.

Mike Whooley
SFFD Paramedic Captain
31 years in and still on the streets.

BTW, I was at the National Fire Academy when the MSP bird went down about 50 miles away and heard a lot of the local EMS and Fire personnel asking some of the very same questions Dr. Bledsoe has been asking all along about air medical transport.
mwhooley
Added Oct 3 2008 7:21PM

Enter comments...
satch512
Added Oct 3 2008 9:19PM

I agree that medicine is always changing and many of the sacred cows that we beleive in must always be challenged. I also beleive in providing good patient care. I also know that 90-95% of calls rotor and ground are basically non-emergent. But I know that in that 5-10% range is the reason why we do what we do. Gutter medicine at it's best. What you fail

to realize is that many EMS systems are different. In the area where I live and work the closest trauma center is 50-60 miles away. The closest Level 3 is 40-50 miles away. The hospital where I'm based isn't equipped to deal with any trauma and critical cardiac is almost always flown out. Ground non-emergent transport is used 80-90% (interfacility). So until you can prove to me that this person isn't having a CVA or an MI or suspected internal injuries I will always fly. When in doubt fly them out! When you or Bledsoe are in the same predicament which mode of transport will you choose? Or is it just our fault that we choose to live in a rural area with no services and we deserve what we get? I'm not a lawyer and I'm pretty sure Bledsoe isn't. so until there is tort reform in this country this is the sad state of medicine in the USA, But I love it! I know there is definitely room for inmprovement, but until you control the blood sucking ambulance chasing lawyers this is what it is. so make the best of it. Obviously Dr. Bledsoe saw his way out of the streets and took it. Congratulations! to him. Now let us do our jobs. This constant critiscism is just annoying. So I ask, ARE WE DOING ANYTHING RIGHT?????
adhdcep911
Added Oct 3 2008 10:41PM

A good article. First I would ask that JEMS get a spell checker.

I'm finishing my 30th year in EMS. I have flown out people who were discharged that day but I can usually justify my reasons for calling the helicopter. The issue is less my judgement and more the standard of care that the Medical Doctors have created. If EMS leaders like Dr. Bledsoe want change, then do it. You the People gave me a standard and now you don't like it.

I was pleased to see a works cited section attached to the article. If we want to earn respect then we need to credit our sources act like the scholars whose respect we want. Research needs to come from the street as well as the University.

Finally, which paper or study said that tourniquets are bad? Literature from military and naval surgeons starting in 1700 or earlier shows that the tourniquet is essential in controlling blood loss during battlefield amputation. I believe I read several passages from Time/Life series titled the Mariners that discuss bleeding control. Also pamphlets from the Shiloh Battlefield Park mention people who die for the want of a tourniquet. My point is that historical data is available, we just need to look for it.

I'm a Paramedic, I take direction from my medical directors. I am finishing a Masters Degree that proves I am capable of learning and thinking. You the People created a Standard of Care for me to follow or explain why I did not follow the guidelines. Until the Standards change I will continue to fly out Patients who need 30 minute extrication, needed or not because I am just a Paramedic.

Layne Bradford BA, EMTP
Layne
Added Oct 4 2008 2:26PM

"We call it "level one by lawyer". I would rather overtreat and fly my patient 60 miles to the nearest trauma center than to take a chance with litigation."

If you aren't capable of accurately assessing your patient's needs, maybe you shouldn't be practicing. Treat your patient, not their imaginary lawyer.
bmac161
Added Oct 4 2008 2:53PM

"One thing to recognize, though, is that mechanism of injury (MOI) is a poor predictor of injury" - Hate to disagree with you Bryan since I have a lot of respect for you, but I find your statement misleading. I read the article you cited and they are referring to MOI ALONE as an indicator (ie falls > 20', etc) HOWEVER, according to PHTLS 6th edition (the course based on the American College of Surgeons-Committee on Trauma) "kinematics can predict

90% of trauma". So, while I agree with you that we shouldn't automatically fly every motorcycle MVA and every rollover, I have to point out that MOI and kinematics of injury should MOST DEFINITELY be used by paramedics to predict probable injuries and the severity of those injuries. My recommendation: call the helicopter every time you hear a high mechanism dispatch. It's silly to call a helicopter AFTER you determine the Pt's status. When medically trained personnel arrive at the scene they can further assess the MOI, the kinematics, determine their patient's status, and cancel the enroute helicopter to preserve resources if their patient is stable. (Final thought: medics who call for helicopters onscene with critical patients are really doing their patients a disservice if their transport times are short to moderate - don't forget that helicopters take a while to get off the ground, are small and cramped, and may simply delay definitive care)
k9cd5qn
Added Oct 4 2008 3:06PM

Interesting thread. adhdcep911 blames the lawyers and Layne blames the doctors. I think that the lawyers and doctors share blame with other persons. First, in regard to lawyers. I agree that we must tread carefully WITHIN REASON. I do a little expert witness work (because I feel I have an obligation to do so). I have never seen a lawsuit against a paramedic for not calling a helicopter. But, I have seen many related to helicpter transport and crashes (in fact, there are three on my desk now). adhdcep911, have you ever been sued? Why the great concern about litigation. Anytime you put the fear of litigation ahead of a patient's best interest, it is time to walk away. Such a stance is legally and ethically indefensible. As a point of clarification, I have never said anything about FP-C. I am familiar with that organization. They are a class act and their exams and certifications are valid. The CCEMT-P is another story. As for the "fat MD" paycheck, I have no apologies. I devoted 12 years of my life to higher education. I put my family through *** for 12 years--especially medical school. I think I deserve what I earn. I could have gotten a business degree or a high-tech degree and started earning big bucks in much less time than I spent in college, graduate school, medical school, and residency. Our great land has some of the best and least expensive universities and colleges in the world. Education is the key to success in this day and age--regardless of the profession. Go pick up a college catalog and apply. Layne is working on his Master's degree. A whole world will open up for him--unfortunately much of it outside of EMS. My grandson came home with a saying the other day, He said, "Every time you point a finger at somebody, 3 fingers are pointing back at you." The civil rights leader Eldridge Cleaver said, "If you are not part of the solution, you are part of the problem." This surely applies to EMS. We must embrace evidence-based practice.
bbledsoe
Added Oct 4 2008 3:23PM

K9cd.....The article in question (Boyle) is about mechanism of injury as a sole predictor of who needs a trauma center. But, there are numerous other articles that have shown that physiological indicators are much better indicators of who needs a trauma center than MOI indicators. Interestingly, this is one of our research areas. There is evidence that shows that ejection from a vehicle is associated with increased risk, but we have been unable to find any evidence for the other MOI categories. Also, you are assuming that medical helicopters make a big difference. They do not. A member of the Maryland legisture recently asked Johns Hopkins University to review and summarize the literature on medical helicopters. Their conclusion was, "Given the high human and financial costs associated with HEMS transport, and the modest benefits realized through these services, careful consideration of how HEMS is being used, and how should it be used in Maryland is needed." I think there is a limited role for helicopters. We probably only need 25% of the ones we have and they must be a part of the EMS system. The utilization criteria need to be significantly scaled back.

This article seems to really have struck a nerve. The late Jim Page was the one who encouraged me to start writing about evidence-based EMS. Jim died before the helicopter industry got out of control. He warned me to be prepared to take some personal shots when emotional issues like CISM, lights and sirens, helicopters, and similar issues are discussed.

He was right.

For Layne, I have a dirty little secret. Most physicians could give a rat's *** about EMS. Recently, former ACEP President Greg Henry wrote, "As a so-called necessary health care expenditure, I think EMS is the largest hoax ever foisted on the American People." There is a growing group of physicians calling for a return to BLS. I very much disagree. But, I think Darwin was correct in that we must evolve or die--no matter how painful the process
bbledsoe
Added Oct 5 2008 12:22AM

Well Dr. Bledsoe I have no plans to hang it up. I love what I do and I love the education. I love the area I work nad the people I work with on the ground and in the Air. I work hard with all of my mandatory educational requirements and training at both of my jobs. So I'm going to be here a while. I myself will not fly out of fear of a lawyer. This is what my Medical Control has me do. Sorry I should have clarified. In turn myself and other Cep's call it Level 1 by lawyer. I have never been sued. I do have my FPC because it is a requirement where I fly. It takes a tremendous amount of CE to maintain but apparently it's not good enough for you. I find that what I do in the air makes me better on the ground and vice versa. I self studied for almost a year and I'm proud that I got my FPC. As far as what is the problem in medicine I can't tell you where to begin. But one thing I do know is ALL of the finger pointing is done by you. You are obviously very smart and some of your articles were interesting, but all of them have the same theme. See the soap box post. Yes, you studied hard and you are a doctor. We are all proud. I'm happy with what I do, could we be better? of course always. I'm just simply saying I'm really bored of the recurrent theme of all your articles. so I ask again...ARE WE DOING ANYTHING RIGHT???
adhdcep911
Added Oct 5 2008 1:00AM

Oh and shucks! I forgot...I will work on my education. Promise! Sorry Yall..Ain't got a Masters or Bachelors just two lil bitty AA's. I'm too busy flyin people on mech or MOI or whatever to pursue my Bachelors degree. So I don't have any good quotes to give you.
adhdcep911
Added Oct 5 2008 1:13AM

Bored by articles? I looked at this year's JEMS.com file. The last was about my technical incompetence, the one before that about EMStock, the one before that about poor pay in EMS and attrition, the one before that about what music people listen to on their IPOD, the one before that about a bright future for EMS, the one before that about National Registry changes, and the one before that about being married for 30 years. They sure don't sound like"the same old thing" to me. Stooping to an ad hominem attack serves no one. Just because you don't like the message, don't attack the messenger. The good thing about the internet is the delete buttton. If you don't like what you read, hit the delete button. Also, two A.A. degrees is something to be proud of--especially if they are related to EMS.
bbledsoe
Added Oct 5 2008 11:02AM

I think there's a need in every industry to challenge the "business-as-usual" mindset. Practices that are based on custom rather than evidence are good places to begin. It takes courage to start that process, and a willing suspension of disbelief to analyze further.

Mike
mgr22
Added Oct 7 2008 3:34PM

Experienced medics & managers have been saying this for years. While we recognize the expertise of medivac crews can be a vital resource, helicopters are in the end ambulances-with their own unique limitations. EMS has painfully learned a few lessons to date based on objective analysis of risk/benefits for ground transportation decisions. Yet treatment guidelines seldom reflect even what we think we know from careful analysis. These emotionally charged debates include the perceived benefit of ALS vs. BLS, Lights & Siren

vs. "with traffic", "stay & play" vs. treat en route, & bypassing local hospitals for specialty centers (Stroke, Trauma, Urgent Angioplasty, and Burn Centers, etc.). Decisions are often driven more by emotion, good intentions, & underlying assumptions vs. outcomes and proven benefit. The same is true for medivac usage. DOES medivac transport ACTUALLY improve outcomes? For which patients? Under what circumstances? Until OBJECTIVE analysis can help us create SOUND guidelines for medivac usage we're left with politics & good intentions-neither of which improves patient care. Bravo for Maryland in calling to review their guidelines-assuming they follow through. Unfortunately medivac ambulances are often the sole participant responsible for crafting their own usage guideline, allowing politics, finances and a cornicopia of "other" factors to influence final guidelines. We can only hope this tragedy moves us closer to better medivac policies.

G Hebert
Chief Paramedic
Hospital Based Paramedic Intercept Service

(my comments reposted from http://www.ems1.com/ems-products/consulting-management/articles/431425-Medevac-guidelines-questioned-after-fatal-Md-crash)
Do Whats Right
Added Oct 9 2008 2:25PM

Decaf anyone?

Mike
mwhooley
Added Oct 14 2008 12:11PM

Whoa...this is a great article and an even better thread. Dr. Bledsoe's stance all falls back on evidence based medicine and the lack of it in EMS. As a paramedic who became an emergency department PA-C, it became apparent the huge difference in between EMS and clinical medicine, and each settings flaws. Yes the prehospital world has its own challenges; however, there is no excuse the mindless mentality that seems to thrive. The system needs to evaluate the needs of the community at large and adapt based new evidence. The "we have always done it this way," status quo has got to be eliminated; instead, committees representing the total health care system need to work together to determine what is best for the people we serve. The use of protocols written by one physician has got to go. A committee who looks at all the facts should dictate what the EMS providers scope of practice should be.

How does this have anything to do with air evacuation? As prehospital EMS providers, we are treating our patients based on thoughts and practices that have little to no validity in medicine. Air evacuation, C-spine precautions, oxygen use, transportation of cardiac arrest patients, trauma triage criteria etc...are all subjects that are not necessarily based in evidence. For instance, the use of an air platform in an urban area such as Baltimore or DC does not make much sense when you balance the risk and benefit gained by "rapid"air transport. On the other hand, if you live in a rural area where the closest facility lacks a surgeon, of course, air transportation would make total sense.

In the end, we need to collectively question our mode of operation, and adapt based on what the evidence is showing us.
PAMedicAdam
Added Oct 15 2008 5:43PM

I live & work on the Navajo Nation in AZ and NM and we must often rely on medevacs. I am a contract Paramedic in NM but I live in AZ and volunteer with a comb FD (as a Basic since our fire district is not ALS. I'm a PM in AZ). We are a long way from nowhere. In AZ our little IHS contract hospital has an "Emergency Department" but is primarily a clinic facility. Don't get me wrong, they do the best they can, just limited by lack of specialized personnel and equipment (do have CT though). We deal with many Level 1 trauma & head injury

victims (lot of ejected drivers and their passengers) and many owe their lives to medevacs. The nearest Level 1 Trauma Ctr is 3 hours away by ground. Our local ambulance only operates ALS 2 days a wk (lack of personnel and their own inherent problems) and sometimes out-of-service multiple days because no one is there to work, even BLS. That leaves the FD, also BLS.

I' m starting a rescue service at the ALS level. The "little" IHS contract hospital is giving me great protocols to match our needs. The ER Director here will be the first to call for a medevac to take pts because of our limitations. My rescue service will also (hopefully, with blessings of our state EMS) be able to do ALS interfacility to rendezvous with fixed-wing (30 miles away in two directions) when rotors aren't available (we have overwhelmed regional air capabilities on many occasions). We have already set a protocol for when we call for air and bypass the ED. In NM the situation is carbon copy, working a long way from anywhere and use rotors frequently.

I have worked in cities like L.A. as a medic where I have seen the futility of waiting for a medevac when a ground unit can transport faster since there is no delay in waiting for the "bird" and the added time of transfer of care. However, like their original missions in Korea and Vietnam, they play a huge role in rural environs. Some will surely disagree but that's the beauty of this country! Freedom of Speech!
AZ_NM_firemedic
Added Oct 17 2008 10:32AM

There should be no disconnect between the practice of medicine under the bright lights or it's practice in the pre-hospital setting, save for location and equipment. Evidence-based medicine protects the patient, the provider, and the agency. Change is good and so is continuing medical education. That's why it is called "continuing" in the first place. I sense a major disconnect between many agency Medical Directors and those who are served by them. Dr Bledsoe's editorial is correct, and if it hits home hard, don't take it personally, do something about it!
thefourjacks