

Joint Position Statement on Emergency Medical Services and Emergency Medical Services Systems

National Association of State EMS Directors and National
Association of EMS Physicians

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Background

In 1966, a National Academy of Science's National Research Council white
paper described inadequacies in the emergency health care available in the
United States. Entitled "Accidental Death and Disability: The Neglected
Disease of Modern Society," this paper cited a diversity or lack of standards
for many aspects of emergency medical services (EMS) and a general
absence of a systemized approach.

Federal response in the early 1970s, through the National Highway Traffic
Safety Administration and the EMS System Act of 1973, addressed the
fragmented delivery of EMS, and set standards for planning and developing
such services within the context of an EMS system. The System Act
addressed the primary prevention of injury and acute, critical illness as well

as methods for comprehensive intervention, from system access and prehospital care through stabilization and rehabilitation, in those cases where primary prevention fails.

Problem Statement

In the past 10 years, there has been no centralized federal effort to continue the comprehensive EMS system planning and development begun in the 1970s. Federal planning and funding have focused only on specific components of the EMS system, such as highway safety, injury prevention, trauma systems, EMS for children, and medical disaster systems. These efforts have not been integrated through one federal coordinating agency.

In addition, much energy has been devoted to debating who is the "most appropriate" sponsor of prehospital services (e.g., EMS as a sub-entity of the fire service, or EMS as a private sector service, or EMS as a third public service). Much of the early efforts in EMS system development and implementation had limited physician input and participation. Substantial energy has gone into the development of detailed standards involved in the designation of specialized critical care services in hospitals.

Many valid reasons exist for focusing on the development of individual components of the EMS system. Standards for individual components have evolved at different paces nationally. Fiscal constraints have compounded this unequal evolution of local EMS systems. Nonetheless, developmental and funding emphasis on individual components of the EMS system, without regard for the existence and needs of the EMS SYSTEM, threatens to fragment EMS. Fragmentation of EMS is as unacceptable today as it was in 1966.

Purpose and Recommendations

The National Association of State EMS Directors (NASEMSD) and the National Association of EMS Physicians (NAEMSP) represent EMS professionals who are involved centrally in the planning, development, and day-to-day direction of EMS systems. The NASEMSD and NAEMSP embrace the concept of comprehensive and integrated EMS SYSTEM planning and implementation. Accordingly, it is the purpose of this joint position statement to encourage the use of the following definitions:

A. Medical Emergency: A sudden and/or unanticipated medical event which requires immediate assistance.

B. Emergency Medical Services: The provision of services to patients with medical emergencies.

Emergency medical services (EMS) has emerged as a field whose purpose is to reduce the incidence of preventable life-threatening and disabling injuries and acute illness whenever possible, and to minimize the physical and emotional impact of injuries and illnesses which do occur. The EMS field derives its origins and body of scientific knowledge from the related fields of medicine, public health, health care systems administration, and public safety.

The effectiveness of EMS is a function of the coordination among many autonomous, yet highly interdependent, professional disciplines. Emergency medical services has become a distinct field with an evolving body of scientific knowledge unique to its purpose and multi-disciplinary composition.

A. Emergency Medical Services System: A comprehensive, coordinated arrangement of resources and functions which are organized to respond in a timely, staged manner to targeted medical emergencies, regardless of their cause or the patient's ability to pay, and to minimize their physical and emotional impact.

Resources of EMS Systems

These are all fundamental resources of a comprehensive EMS system which by its very nature is dynamic and will change over time. Therefore, the following list may be expanded according to growth of the field and changing state of the art.

I. Professional, Occupational, Lay Disciplines

- A. Prehospital emergency medical care personnel
- B. Physicians
- C. Nurses
- D. Emergency medical dispatchers/public safety dispatchers
- E. Directors and administrators
- F. Public safety first responder personnel
- G. Other allied health care providers

H. Lay citizens trained in system access, CPR, and first-aid

II. Facilities, Agencies, and Organizations

A. Hospitals

B. Ambulance and first-responder services (land, air, water)

C. Fire departments, rescue squads, law enforcement agencies

D. Regional and state EMS planning, coordinating, training, facilitating, and regulating agencies

E. Educational programs

F. Local, regional, state, and national EMS professional associations

G. Federal EMS funding agencies

H. National EMS voluntary standard-setting organizations

III. Equipment

A. Ambulances and rescue vehicles

B. Medical equipment and supplies

C. Extrication devices

D. Communications equipment

E. System access equipment

F. Protective equipment

G. Personal protection equipment

H. Educational adjuncts

I. Automated systems

IV. Funding

A. Federal, state, and local agencies

- B. Dedicated revenue sources
- C. Reimbursement mechanisms
- D. Private sector donations

Functions of EMS Systems

Listed below are all the fundamental functions of a comprehensive EMS system, which by its very nature is dynamic and will change over time. Therefore, the following list may be expanded according to growth of the field and the changing state of the art. The resources listed above are integrated to provide the following functions:

I. System Organization and Management

- A. Authority to direct the development and allocation of system resources
- B. Authority to develop and implement local, regional, and state infrastructure

II. Medical Direction

- A. Direct (on-line) medical direction
- B. Indirect (off-line) medical direction
- C. Triage and transport protocols

III. Human Resources and Education

- A. Volunteer and career recruitment for prehospital and hospital disciplines
- B. EMT, physician, nursing, medical dispatch and other specialty training and continuing education programs
- C. Critical incident stress debriefing and other support services

IV. Communications

- A. System access (detection and recognition by the patient and pre-response elements), 9-1-1, or other central access
- B. Dispatch (including emergency medical dispatch)

C. Medical direction functions

D. Interagency/mutual aid/disaster communications

V. Transportation

A. Emergency ground, air, and water transport

B. Non-emergency, medically supervised transport

VI. Definitive Care (facilities)

A. Acute care facilities

B. Rehabilitation facilities

VII. Quality Assurance/Improvement, Evaluation, and Data Collection

A. Patient run record collection and processing

B. Linkages to hospital records for outcome studies

C. Linkages to trauma registries

D. Linkages to other specialty EMS data systems

E. Ongoing review of performance of all system medical and operational elements

F. System improvement mechanisms

VIII. Public Information and Education

A. Prevention education

B. System access information

C. EMS system education for system participants, elected officials, and general public

D. Citizen CPR and first-aid/self help training

IX. Disaster Medical Services

A. Integrated planning

B. Mutual aid and mass-casualty incident and incident command system plans and training/exercises

C. Disaster medical equipment caches

D. Triage system

E. Integration with other emergency management agencies

X. Research

A. Systems

B. Interventions

XI. Care of patients with special needs

A. Designated trauma care systems

B. Pediatric care systems

C. Poison control systems

D. Mental health facilities

Stages of EMS Response

The resources and functions are coordinated through specific stages of EMS response to medical emergencies. These stages define the scope of the system:

A. Prevention

B. Detection

C. Notification

D. Dispatch

E. Pre-arrival

F. On-scene

G. Transport and facility notification

H. Emergency department/receiving facility

I. Interfacility transport

J. Critical care

K. Inpatient care

L. Rehabilitation

M. Follow-up

Targeted Medical Emergencies

The medical emergencies targeted by this staged, coordinated EMS response include those listed below; this list may be expanded according to growth of the field, changing patient needs, and changing state of the art.

A. Behavioral emergencies

B. Burns

C. Trauma

D. Cardiac emergencies

E. General medical emergencies

F. Neonatal/perinatal/pediatric emergencies

G. Obstetrical emergencies

H. Head and spinal cord injuries

I. Poisoning

J. Geriatric emergencies

Position Statements

The provision of EMS is a complex process that consists of multiple components that must be integrated into a system. The NASEMSD and NAEMSP believe that the resources, functions, response stages, and targeted emergency medical conditions described in this statement are the sub-components of an EMS system.

For an EMS system to be effective, it must be developed and implemented according to a plan that addresses all of these sub-components. Undue emphasis to any given sub-component of an EMS system that causes a neglect of other sub-components will induce continued fragmentation which compromises system effectiveness. Whenever possible, emphasis on any sub-component (e.g. allocation of funding for the development of improvement of a sub-component) should be in proportion to scientifically established need. Such efforts should be assigned priority with regard to the developmental needs of the system as a whole.

The delivery of EMS is pluralistic by its very nature. That is, many types of agencies and institutions have been able to provide emergency medical care successfully. No one type of ownership or sponsorship of EMS provider agencies or institutions clearly is superior in all situations.

When EMS, at any response stage, is provided by an agency or institution that also provides non-EMS services, the role and responsibilities of that agency or institution as a sub-component of the EMS system must not be jeopardized by its non-EMS role(s) and responsibilities. Quality patient care will depend upon total commitment to the development and operation of an integrated and comprehensive EMS system.