# Abuse of medical services essay

ASSIGN
BUSTER

Abuse of the Emergency Medical System 4/8/2010 Running head: ABUSE OF THE EMERGENCY MEDICAL SYSTEM Abuse of the Emergency Medical System The system of emergency medicine is often abused. From 911 calls, to visits at an emergency room (ER) we are experiencing an overload of non-emergency patients, causing the systems to become backed up and consuming money and time from all people involved. This abuse largely stems from the general public not being properly educated with the true functions of the system. Thus, seeking alternate systems would be beneficial in several ways.

An emergency medical service (EMS) has a limited number of ambulances available, based on the number of runs usually required per time of day, and considering the population it serves. At times all ambulance units are out on runs (i. e. service calls) and a true emergency 911 call comes in with no ambulance units available to respond until a unit clears its scene.

The alternatives that are taken to avoid this event are, employees on stand-by call; a supervisor in a chase car (non-patient transport vehicle), and/or mutual aid agreements with adjacent counties EMS service.

Employees on stand-by call are the most widely used solution to solve moments when all units are tied up on a scene. The downfall is you are dependant on employees signing up for the call and/or the distance the individual lives from the station he/she is reporting to. More times then not, by the time the employee reaches the station the need for them is over. EMS services are timed in minutes.

Sometimes those minutes are critical in the timeline of a patient suffering from a heart attack, or stroke, or respiratory distress.

A supervisor or medic in a chase car lessens the need for advanced life support (ALS) units so an agency can employee more basic life support (BLS) units. This will allow an emergency medical service room in their budget for more units on shift at a time or the accessibility to purchase needed equipment, or upgrades, or for better training exercises. The hindrance is a finite number of medics in a chase car able to respond with a BLS unit.

They too are a limited resource that is not always available. A mutual aid agreement between counties can be an EMS's savior.

In 2007 there was a fully occupied charted bus that drove head-on into a bridge column on I-65 near the town of Bowling Green, Kentucky. Medical Center EMS handled the accident and had 5 units on shift spread over two counties available to respond.

Three other ambulance services were contacted to respond through a mutual aid agreement among Barren County, Edmonson County, and Simpson County. In total 13 ambulances, and 5 helicopters, and a fixed-wing medical aircraft on the ground at the local airport responded to that particular event.

While this was happening and with all units tied up on a life threatening run, a patient suffering from a nosebleed called 911 and all that was available to respond to the call was a fire truck. Because none of these solutions are failsafe, there can occur a time that a true emergency is put on hold with the

911 staff because an ambulance has been dispatched to the scene of a panic attack, or someone with a minor injury, or someone just calling because he/she is lonely and wants the company of the medical staff. The reasons for non-emergency 911 calls are countless.

Due to liability issues if a person calls for an ambulance and says they want to be transported to the ER they must be transported. A common misconception is that if one is taken to the hospital in an ambulance one is then immediately seen by a doctor. This is untrue as the patient will be screened by a triage person just like everyone else. If their situation is deemed non-life threatening then they are sent to the waiting room to join everyone else.

The national average wait time from the ER door to doctor visit is 222 minutes, or 3 hours, 42 minutes (Costello, 2006).

There are times when a patient will call 911 from the ER to be transported to another hospital. While these calls were once ignored by 911 dispatchers, they are now taken seriously after a California woman in 2007 died of a perforated bowel in the ER lobby after dispatchers refused to contact paramedics to transport her to another emergency room because she was already at a medical facility (AP, 2007). Since this event, if a patient calls from an ER with the desire to be transported to another ER for any reason, an ambulance is dispatched. Once the patient arrives at the ER by ambulance or other means they are triaged.

Triage refers to a nurse evaluating the patient and determining their immediate medical needs. If the patient is experiencing life threatening

symptoms he/she is taken back immediately to be seen by a doctor if a room is available. If no room is available they are moved to the top of the waiting list and observed closely. If the patient is judged to be experiencing non-life threatening symptoms he/she is added to the bottom of the waiting list to be seen when a doctor is available. While these extended wait times are stressful to the patients, they can also be stressful to the medical staff involved.

With the ERs becoming overly crowded with non-emergency patients as many as one-quarter of all heart attack patients have to wait up to 50 minutes or longer before seeing a doctor (Gordon, 2008).

This is a very dangerous trend we are experiencing in our ERs and a solution has to be found. There are alternative possibilities that could be implemented to reduce the wait times, if not eliminating them altogether. One of the simplest solutions to eliminate delays is to have a nurse triage the patient on the phone as soon as the patient calls 911 and filtering out the non-emergency calls.

This would lead to a less crowded ER, free up ambulances so they are readily available for the true emergency calls, while reducing healthcare costs. The 911 call center in Richmond, Va.

is the only service using this phone triage-by-nurse program fulltime. Calls to the 911 center that are initially determined to be low priority for being a true emergency are shifted to a registered nurse. This screening nurse would ask a series of scripted questions to help determine what kind of care is needed.

The nurse would then possibly recommend treatment at home, or make an appointment for the patient with a doctor or a clinic, or send a taxi or bus for the patient to be transported somewhere other then an emergency room (Halladay, undated). There are many reasons that the wait time at the ER can be so extensive. All injuries and illnesses that need medical intervention are time sensitive.

The longer the wait, the more damage can occur to the patient because they are deprived of basic needs for survival, such as blood, oxygen, electrolytes (potassium, sodium, etc. , sugar, water, immunity, skin integrity, and the like. Extended wait times to be seen in the ER are partly determined by factors such as ratio of physician and staff to patient, laboratory turnaround time, x-ray turnaround time and average length of stay. (Sharon, 2008) It’s not uncommon for a patient to wait four hours for the result of a ten minute lab test.

A probable solution for the 222 minute national average wait time has been found at Gilbert Hospital located in Gilbert, Arizona. Gilbert Hospital has an average wait time from “ door to doctor” of 31 minutes.

While they are a full service acute-care facility, their solution was to offer services of which the community has the greatest need, not just what represents the best financial returns (PRNewswire-USNewswire). Gilbert Hospital has created a framework that most emergency rooms can employ to help their patient care with shortened wait times.

While they have a waiting room, it is usually by-passed and the patient goes straight to triage where they will fill out minimal paperwork for registration

and reason for visit. From there, the patient will probably be taken to a hospital room.

Each hospital room is equipped with its own computer so staff can easily locate or update your information. They have several on-site facilities ready when they need it. They staff fulltime; a laboratory, X-ray, ultrasound, CAT Scanner, and MRI machine.

(Lorren, 2009) Gilbert Hospital is even putting your pre-registration on their website. Walk-in care clinics have somewhat reduced the ER wait times, but they have limited business hours and can also have extended wait times. If these clinics would extend their hours to a 24 hour operation, a drop in ER wait times would be expected to occur as well.

Staffing these facilities with several nurse practitioners instead of all physicians would lessen budget constraints, while giving more options to people with healthcare concerns. Public service announcements (i. e.

TV ads or written pamphlets placed at healthcare facilities) that teach the general public when to call 911 or visit the ER would also reduce the overpopulations of the ER waiting rooms. This would be a cost-efficient way to teach the 13 general reasons to contact emergency services. (i. e.

Difficulty Breathing; Chest or upper abdominal pain or pressure; Fainting, sudden dizziness, weakness; Changes in vision; Confusion or changes in mental status; Any sudden or severe pain; Uncontrolled bleeding; Severe or persistent vomiting or diarrhea; Coughing or vomiting blood; Suicidal ideations; Difficulty speaking; Shortness of breath; Unusual abdominal pain)

While we continue to experience long wait times at the ER or delays in ambulance response times for 911 calls, we continue to look for measures to lessen this problem.

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