An emergency medical services controversy in Nova Scotia: What is expanded-scope EMS?

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RÉSUMÉ : Les services médicaux d'urgence d'application élargie (SMU) est un sujet d'actualité qui demeure une énigme pour plusieurs. Une vue d'ensemble des SMU d'application élargie prendrait en considération quatre variations.

La première, les SMU **aigus, non planifiés** (d'application élargie) inclurait des protocoles de «traitement et de congé» pour des problèmes comme l'hypoglycémie, les traumatismes mineurs et les blessures. Cette variation intégrerait également le concept de SMU à «choix multiples», où les préposés aux SMU évalueraient l'état du patient et auraient le choix de le transporter vers un département d'urgence, vers une clinique ou un autre établissement de soins, ou de le traiter et de lui donner son congé. Dans un tel système, le protocole offrirait la flexibilité aux répartiteurs médicaux d'orienter les appels vers une ligne Info-Santé ou d'organiser un transport non ambulancier. Ce type de SMU pourrait aussi permettre l'application des fonctions traditionnelles des SMU dans de nouveaux environnements, comme par exemple donner aux préposés aux services médicaux d'urgence la responsabilité d'équipes d'arrêt cardiaque dans les hôpitaux..

Les SMU **non aigus, planifiés** (d'application élargie) incluraient des initiatives dirigées par les SMU qui établiraient un pont entre la médecine d'urgence et la santé publique. Celles-ci comprendraient, par exemple, des programmes communautaires de vaccination, des programmes d'évaluation de l'état de santé à domicile, des soins prénatals et des visites de suivi pour la vérification de plaies, l'administration intraveineuse d'antibiotiques ou de médicaments après une visite à l'urgence, et des programmes d'observance de traitement.

Le «service» d'application élargie fait référence aux initiatives de prévention et d'éducation dirigées par les SMU, comme la prévention des blessures (p. ex. le port du casque de bicyclette, les programmes de contrôle de l'alcool au volant) et l'éducation des citoyens (p. ex. la RCR et l'abandon de la cigarette).

Les SMU **cliniques, hospitaliers ou en région éloignée** (d'application élargie) intégreraient une nouvelle classe de préposés aux SMU ou dispensateurs de soins intermédiaires qui travailleraient avec les médecins, possiblement par le biais de la télémédecine. Ces préposés s'acquitteraient principalement de tâches spécifiques, comme poser des plâtres, faire des points de suture et extraire des corps étrangers oculaires. Avec une certaine formation post-secondaire, ils pourraient avoir la possibilité de poser des diagnostics et de prescrire des médicaments, un peu comme un «assistant médecin».

Préparez-vous! Les SMU d'application élargie s'en viennent.

Much has been written about "expanded-scope" EMS in recent years, both in peer-reviewed and non-peer-reviewed literature. The term has crept into the lexicon of paramedics, emergency physicians and policymakers. It has become a hot topic at EMS conferences and on Internet chat sites. However, the definition of expanded-scope remains nebulous. It seems to mean different things to different people at different times. It is confusing to argue the merits of expanded-scope EMS (whether they are medical, fiscal, social or political) without clearly defining the term.

Before addressing expanded-scope EMS, it is helpful to define "traditional-scope" EMS. Put simply, this is the out-of-hospital, acute health care provided by paramedics

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responding in ambulances and transporting to emergency departments. Most would also include first responders and inter-facility transport (air, ground or critical care) in the description, and historically, many EMS systems have participated in more diverse activities than these, but the current discussion will be limited to the definition above.

Expanded-scope EMS is anything that the EMS system does that falls outside of this traditional definition. I propose that expanded-scope EMS can be broken down into 4 different types or quadrants. Although this is arbitrary and there is overlap, it provides some consistency and allows us to compare apples to apples when we argue the benefits (or lack thereof) of "expanded-scope." The proposed categories of expanded-scope EMS are the following.

1. Acute, non-scheduled (expanded-scope of practice)

This quadrant would include traditional EMS acute care protocols as well as protocols that move beyond into the more controversial realm of "treat and release."[1,2] "Treat and release" may be safe and feasible in patients with problems such as hypoglycemia, minor trauma, or wound care issues, although this has not been validated. The acute, non-scheduled quadrant would also include the concept of multi-options EMS.[2-4] In other words, medical dispatchers would be given protocol-based flexibility to refer calls to an advice line or to arrange transportation other than an ambulance. Paramedics, after patient assessment, would have the option to transport to the ED, to a clinic or alternative site, or to treat and release.[2] This quadrant would also include traditional-scope EMS being practised in new settings, for example, paramedics running an in-hospital cardiac arrest team.

2. Non-acute, scheduled (expanded-scope of practice)

This quadrant would include EMS-led initiatives that bridge the gap between emergency medicine and public health.[5-9] Examples include community vaccination programs, home health risk appraisal programs, and even prenatal or postnatal care. It might also include post-ED visits or post-admission follow-up to provide wound checks, IV antibiotics or medication and treatment compliance programs. Such a service could potentially prevent ED revisits, readmissions and exacerbations of chronic diseases.

3. Expanded-scope of "service"

This quadrant would include EMS-led primary prevention and educational initiatives, such as injury prevention programs targeted at bicycle helmet use, boating safety or drunk driving.[10] Already, EMS systems are providing educational initiatives like first aid, citizen CPR, and smoking cessation programs.

4. Clinic, hospital or outpost-based (expanded-scope of practice)

This quadrant would include a new breed of paramedic or mid-level provider.[11] These practitioner would work alongside or in close contact (possibly using telemedicine) with a physician. They would be largely task oriented, performing procedures like casting, suturing and removing ocular foreign bodies. With some post-secondary education, they could be delegated some limited diagnostic and prescribing privileges, much like a "physician's assistant."

Clearly, these four categories of expanded-scope EMS are very different. To debate the pros and cons of expanded-scope EMS without defining and differentiating these quadrants is, at best, confusing and, at worst, counterproductive. Once defined, however, we can move ahead with a methodologically sound approach to evaluating expanded-scope EMS.[12]

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