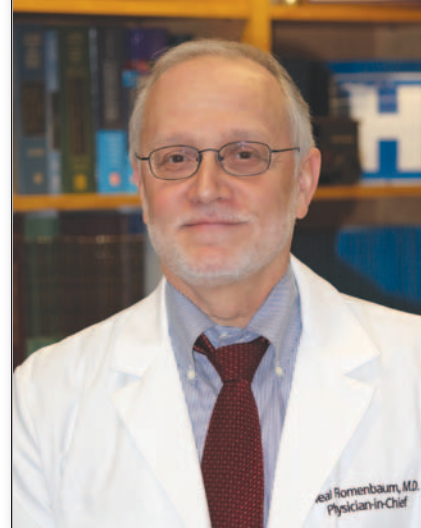


Neal Flomenbaum, MD
EDITOR-IN-CHIEF



An Unnecessary Diversion

A book about emergency medicine by Brian Zink is entitled *Anyone, Anything, Anytime*. As emergency physicians, we believe this title is true, except of course when our emergency department is on ambulance diversion. More than 30 years after EMS systems in many cities began diverting ambulances away from overcrowded EDs to other nearby facilities, the pros and cons and advantages and disadvantages of this practice are still being argued.

First, to clear up a misconception, the main purpose of ambulance diversion from an EMS perspective is not necessarily to give overwhelmed EDs brief respites from new ambulance cases and to allow the patients already there to be properly evaluated and treated. Rather, it is to enable EMTs and paramedics to find an ED with an empty gurney and enough space to allow them to transfer their patient and respond to others.

Ambulance diversion can offer a partial solution to ED overcrowding when there are nearby hospitals to divert to, patients are willing to be taken to other hospitals, and there is a well-organized EMS system that responds to hospital information and diversion requests. Typically, such requests are based on the number of patients already in the ED and/or a lack of available space and necessary equipment, such as monitors and ventilators.

Several types of ambulance diversions are sometimes considered based on the patient's age (pediatric or adult), diagnosis (psychiatric or "EDP"), and prehospital triage classification (critical, noncritical, and total). A newer form of EMS-directed ambulance diversion in New York and other cities is referred to as "ambulance redirection" from the site of a call to a hospital that ordinarily would not have been designated first. When there are three or more ambulances on site and/or the first-choice hospital is unable to return ambulances to service in less than 30 minutes, patients are automatically redirected to other facilities until conditions change.

Whichever system is used, however, diverting ambulances from one hospital to another will probably soon cause the nearby hospitals to become overburdened until they too request diversion and this domino effect will typically cause EMS to cancel all prior requests for diversion until the crisis ends and the next round begins.

Over the past several decades, these cycles have been repeated tens of thousands of times all over the country while hospitals continue to reduce their inpatient capacity or close, and increasing numbers of patients continue to come to EDs for care. Time-consuming and frustrating, ambulance diversion is at best a Band Aid applied

to a rapidly hemorrhaging system. So why even bother with ambulance diversion instead of insisting that each hospital care for the patients in its own catchment area? Probably the best reason to allow ambulance diversions is the psychological boost it gives an ED staff who believes that afterwards the endless influx of new and very ill patients will stop or at least slow down. At the same time, ED providers do understand that ambulance diversion cannot prevent people from coming to EDs by their own means or by non-911 private or volunteer ambulances.

All of this is not to say that EMS systems cannot or should not make ambulance diversion an important part of preparedness efforts and an aid to hospitals experiencing sudden surges of patients. Information about a hospital's ED space and equipment, the number of patients currently in the ED, the rate of patients registering there per hour, the number of ambulances at a particular facility at one time, ambulance turnaround times, and any special hospital designations, such as *level I trauma, burn, stroke, and chest pain*, can and should be considered to ensure that a patient in an ambulance will be taken to the best available hospital in the shortest possible time. Otherwise, redirecting ambulances is an unnecessary diversion from the real issues. **EM**