NEVER ROUTINE.  
No call is ever run of the mill  

Baby does it.  
PAIs deliver when nature hastens  

The National Academies of Emergency Dispatch  

Swine Flu.  
CDE introduces newest protocol  

Navigator  
Bringing people together  

THE JOURNAL  
OF EMERGENCY DISPATCH  

May/June 2009
Your newest trauma tool isn’t in here.

Seriously injured patients rely on you to give the best medical attention and care. To do that, you need knowledge, experience and the proper tools. That’s why the Centers for Disease Control and Prevention (CDC) has released the widely endorsed Field Triage Decision Scheme: The National Trauma Triage Protocol to help EMTs and paramedics choose the best transport destination for trauma patients. Designed in partnership with other leading organizations and experts in injury care, the Decision Scheme has been published in the prestigious MMWR Report & Recommendations. It’s a valuable tool that can help your EMS system save lives.

Get a free copy of the Field Triage Decision Scheme: The National Trauma Triage Protocol, the MMWR and other free resources at www.cdc.gov/FieldTriage
Join the dispatch community in celebrating a profession and its protocol through coverage of our annual conference, this year held in Las Vegas.

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30 years. From its beginnings in Utah, protocol continues march around the world

**Feature**

Lack of regulations puts dispatch in vulnerable position

Ruptured cord adds alarm to already anxious situation

Baby times two plus accidental choking make day to remember

Man follows dispatcher's instructions to the letter following car birth

CPR instructions puts breath back into baby
Missing Bill. Making the best out of trying situations is something we all can do.

Scott Freitag, NAED President

I told a story about Bill Boehly at the Navigator conference, one of a million that could be told to show the type of guy he was. As those who knew him will agree, there wasn’t much that could spoil his good nature, not even landing nearly up to his chest in mud while attempting his final shot for the 18th hole during a raging North Carolina thunderstorm.

That’s exactly what happened to Bill.

Bill and I were away from Salt Lake City on NAED business and went golfing during a free afternoon. A storm blew in but we decided to stay since this was the last hole in our game. Bill takes a swing and the ball lands near the green on the other side of a creek from where he stood. He was in a hurry, expecting a phone call, so he decides to jump the creek rather than wait for me to arrive in the golf cart. He finished his phone conversation buoyed by mud.

I told this story during the closing luncheon held on the last day of Navigator as a tribute to our good friend. Bill died in February 2009, several months after he was diagnosed with pancreatic cancer, leaving a tremendous personal and professional void. The story exemplifies his character, sense of humor, and dedication to Priority Dispatch Corp.™ and the NAED®. Even those in the audience who never met Bill laughed at the story. He probably would have joined in.

The stories told at Navigator are more than fillers, or ways to pass the time while waiting for the technical details to catch up with the intended program. Everyone attending Navigator is in some way attached to an emergency communications center. We may not share the exact same sense of humor, but we do belong to a profession that demands we have one. We've learned how to make the best out of trying situations.

It's not easy being a 9-1-1 dispatcher. We never know what the next call will bring or the emotional state of the person making the call. The job not only requires the ability to help someone through a crisis but, also, the empathy and expressive control to take the distressed caller from a reactive to a proactive response. One call arrives, and the dispatcher disconnects from a particularly tough call, the only relief may be the sort of graveyard humor seen in high stress jobs. It's a way of protecting us from the horror or tragedy we've witnessed in our heads from the situation described over the phone.

Then there are the calls from people abusing the system who knowingly make outrageous calls that consequently jeopardize the lives of others. Others may ask silly questions or demand police on the scene to resolve a situation frustrating the caller. Who hasn’t picked up a call from a driver who’s angry that another car cut in front at a fast-food drive-thru, or something similar? The absurdity makes us laugh while, at the same time, it adds to the day's pressures, especially when police are sent to make sure there isn't some type of emergency happening. Each time it happens, those calls keep officers from keeping the rest of us safe.

Navigator gives us the opportunity to share these experiences. Time and time again people tell me how important it is to hear stories about calls similar to the ones they receive. The same goes for issues internal to the communications center or the "bad" press that might develop following an often sensationalized media investigation of 9-1-1 calls. Navigator lets us know we're in this together and, also, gives us the rare occasion to acknowledge our collective efforts. We leave re-energized and ready to approach our jobs head on.

This year's Navigator was no different and, for some, the conference was especially inspiring because of the celebration of the 30th anniversary of protocol. The only part missing was Bill. He could have told the golfing story much better, if he would have told it at all. Outside his own family, this community was his life. Not even a plunge into a muddy creek could keep him from making the best of a situation.
Swine Flu. Taking the pandemic by surprise

Jeff Clawson, M.D.

The National Academies of Emergency Dispatch® (NAED) has received a flood of letters and phone calls about the appropriate use of Protocol 36 Pandemic Flu and the rapidity in which the Protocol and technical documents relating to its application were released simultaneously to the reported outbreak and word of a possible pandemic. The following information should answer your questions.

The first question — proper use — is answered on our website. By going to http://www.emergencydispatch.org, you can download the information. The site includes a "Clarification" document that explains the differences between the Severe Respiratory Infection (SRI) surveillance and symptom identification tool and Protocol 36; the information also clarifies when to use them. Any emergency communication center, whether Medical Priority Dispatch System® (M PDS) user or not, can use the printed tools under a special limited use license contained within them. However, they cannot be incorporated into any 3rd party products or CADs, modified in any way, or re-distributed for any other uses.

The second question — our quick response — takes some explanation. Those familiar with the Academy and its annual Navigator conference held in late April have been particularly interested in the speed of our posting considering most of the staff's remote presence in Las Vegas for the conference during the height of the swine flu spread from Mexico to other parts of the world; first in the United States.

With virtually the entire NAED staff and parts of the world; first in the United States. The Academy has a seemingly impossible?

The simple reason boils down to our proactive agenda. The Academy has a standing Chemical, Biological, Radiological, and Nuclear (CBRN) Fast Track Committee that constantly monitors the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), Health Canada, U.K. National Health Service (NHS), the Australian Government Department of Health and Ageing, and other sites for emerging trends and possible symptoms of new threats. We keep a close watch on these worldwide health trends and plan accordingly. In the case of swine flu, the determination that a pandemic was nearing was becoming apparent on about the weekend of April 25.

We were nearly ready.

Earlier last year, anticipating a potential avian flu outbreak in the coming fall, the NAED had begun work on several items for both ProQA® and cardset users. When the swine flu hit, the CBRN Fast Track Committee conferenced on Monday, April 27, and formally requested an immediate release of all materials relevant to swine flu. Since the materials were not due to be fully completed until this summer, 20 Academy and Priority Dispatch Corp.™ (PDC) experts met later that same day in Las Vegas and conferenced with the remaining writing, logic, programming, and translation staff in Salt Lake City.

Beyond all predicted likelihood, the materials—SRI responder information, surveillance adjustments, and response modification software—were finalized, tested, translated into five languages, and posted on both the NAED and PDC websites within 48 hours. With key management people from NENA also in Las Vegas, they joined in the effort to post the links on their sites, as did the CDC and others. The National Metropolitan Medical Directors consortium was also notified on the afternoon of April 29 of the upcoming posts. Notification of all e-mail registered MPDS agencies, and the reaching out to even non-MPDS users, was accomplished. All were notified to check the NAED website daily for updated materials.

The Academy has so far received stellar acknowledgment from many communications centers, EMS organizations, and government officials, and numerous thank you letters for its pre-planning and the successful cranking out of all finished materials within 48 hours, as well as having a system in place to update and disseminate them immediately. Had the NAED not set up a CBRN Fast Track Committee at Navigator in 2003 and accomplished further protocol creation system in 2008, there would not have been any materials at all. When the chips were down, no other 9-1-1 related group came up with anything remotely like the full suite of materials posted by the NAED — and in 48 hours from CBRN alert to completely mobilize.

I am exceedingly proud of the hard work provided by the many people who helped with what turned out to be a nearly superhuman, but not totally unpredictable, international effort.

For future reference, the Academy regularly posts important bulletins and updates on the home page of its website. This site is an important and commonly traversed vehicle for the release of emerging, vital information. Please check it regularly.
The tabletop Tomy Atomic Arcade Pinball game featured bells, power bumpers, and automatic scoring against a background of mushroom-shaped clouds. Manufactured in 1979, it’s no telling how well this game sold considering the accident at the Three Mile Island nuclear power plant near Middletown, Pa., in March of that same year. The meltdown propelled *The China Syndrome* into a blockbuster film among a nuclear energy apprehensive public, although quite by coincidence its release date was but 12 days before the disaster.

During the same year, 1979, two toys landed on the positive side of success. In September 1979, two 30-year-old Canadians came up with an idea for a game testing our knowledge of fairly inconsequential stuff. Trivial Pursuit sold 45 million copies worldwide in its first five years of sales. At about the same time, Babyland General Hospital in Cleveland, Ga., began producing a line of dolls, each slightly different from the next. The ingenuity of dolls, each slightly different from the next, was almost immediate hit, so much so that the Cabbage Patch doll was almost as recognizable as the *Monopoly* and *Barbie* dolls. The year 1979 also marks the beginning of something big in the world of EMS. As we’ve chronicled over the past several issues of *The Journal* and celebrated at Navigator, this year—1979—heralds the introduction of emergency dispatch protocol. The medical protocol was not the immediate success of the Cabbage Patch; no one was ducking fistscuffs over the purchase of medical cardsets.

Of course, any anniversary begs the question of where things you’re celebrating will be in the next same number of years. Unlike dolls pushing parents over the edge and questions leading baby boomers down memory lane, you can bet protocol will continue far into the future no matter the coincidence of world events or the mood of an often-capricious public. After all, wouldn’t you rather be clutching a phone connected to an emergency center using protocol than a vintage Cabbage Patch in your time of disaster? I know I would.
Dr. Jeff Clawson isn’t exaggerating when he mentions National Academies of Emergency Dispatch® (NAED) co-founder Bill Lloyd in the same breath as the existence of the fire, police, and medical protocols.

“We wouldn’t be where we are today, much less be here, if it wasn’t for Bill,” Dr. Clawson said during his remarks at the Navigator 2009 closing luncheon.

The Medical Priority Dispatch System® (MPDS) meant much more than a place to invest the capital Bill earned during his lucrative career in commercial and residential real estate. He was 100 percent behind the doctor’s vision.

“I was more than a financial investment,” said Yvonne “Bonnie” Lloyd, who celebrated their last wedding anniversary together in March 2009. “He wanted something that had meaning, something that would be of service to other people.”

Bill was that way in all he did, even in the way he lived for eight more years—seven longer than the prognosis given at the time he was diagnosed with a malignant sarcoma. He died April 26, 2009, at his Salt Lake City home from complications related to his career.

“He is a death much like his life, very sweet,” Bonnie said. “That may sound odd, unless you knew Bill. He loved life. To him, life was one grand adventure after another.”

Those traits about Bill—curiosity and optimism—help explain the Halloween costume he designed to look like a tumor and the Mr. Clean look he created after chemotherapy robbed him of his full head of hair. They also explain the aggravation he feigned months into chemotherapy during an NAED office meeting.

“No one had ever seen Bill lose his temper,” said Priority Dispatch Corp.™ (PDC) Director of European Operations Tudy Benson, who developed a close friendship with Bill during the years they shared an office wall at the NAED. “But there he was, standing up at a meeting, threatening to pull out his hair from his frustration at the rest of us sitting around the table.”

The hair he did yank came out in clumps he laid on an open paper napkin. He had planned it that way, knowing the rest would go that evening when his six grandchildren took turns at shaving his head bald. Some might say his action at the meeting was his way of bullying death. But it was more than that, Bonnie said.

When the chemotherapy was no longer effective, he decided to build up his immune system with an intake of essential vitamins, minerals, and enzymes (238/day). He ate fresh fruits and vegetables and plenty of red meat. He drank gallons of juice.

“His was a death much like his life, very sweet,” Bonnie said. “He never complained,” she said. “He protected loved ones from witnessing his suffering with humor. He wanted to make sure people would approach him, not worried about what to say. His cancer was not his private battle.”

The diagnosis ignited a zest intensified by the uncertainty of time. A patriot President Thomas Jefferson would envy, Bill gathered his family—six children and a growing number of grandchildren—for flag raising ceremonies on the Fourth of July, resplendent with songs and speeches. Bill retired full time from the NAED and from his position as Director of Contracts and Legal at Priority Dispatch Corp., and he and Bonnie traveled extensively around the world. They took their children, two at a time, to Paris, condensing days of sightseeing into long jogs around his favorite city to point out the places he found remarkable.

When the cancer went into remission, family and friends gave a shout, declaring him a conqueror. His optimism, combined with intensive medical treatment, had cheated death in a fashion similar to his full recovery from a serious car accident occurring years earlier while a senior in high school.

But the cancer did not stay in remission.

One year later, the monster returned. Bill began a series of operations and treatments to remove and shrink the tumors. In true Bill style, he used the power of positive thinking; he wanted to face the disease head on in his own terms through research and prayer.

When the chemotherapy was no longer effective, he decided to build up his immune system with an intake of essential vitamins, minerals, and enzymes (238/day). He ate fresh fruits and vegetables and plenty of red meat. He drank gallons of juice.

Bill died, knowing he had fought death as honorably as he had lived life.

Bonnie said the last eight years of their life brought an intense closeness to a relationship sparked from a distance during a junior high school assembly and guided by their faith.

During his final days, they read the sweetheart letters written back and forth years ago, before their marriage, while he was serving a mission for his church and through his second year as a student of architecture at Harvard College in Cambridge, Mass. They married in 1966. She never lost track of the letters, despite several moves related to his career.

“He was a good man who wanted nothing more than to make the world a better place,” Bonnie said. “He did that. He lived life to the fullest.”

1941–2009

Life to the Fullest.
Bill Lloyd walked a line honorable to his beliefs

“The Journal
To complete this CDE, you will need to access the Protocol 36 PDF document on the Academy website. Go to www.emergencydispatch.org/flu.php, scroll down to #2, and select the link entitled “Protocol 36 - Pandemic Flu.” The PDF document can then be viewed or downloaded.

The International Academies of Emergency Dispatch® (IAED) has developed Protocol 36: Pandemic Flu (Officially Announced), for managing EMD triage and locally limiting EMS responses in the event of an official pandemic flu outbreak. This protocol exists in both card format and in the computerized ProQA® program.

Because Protocol 36 alters the way emergency medical dispatch is determined, and changes EMS responses to certain patients, it must be implemented with a complete understanding of its use and underlying dispatch objectives. Since Protocol 36 is not used during normal (non-outbreak) operations, it requires advanced planning and setup, with “just-in-time” training and orientation for EMDs, as well as EMS administrators and responders.

Limitations for Protocol 36 use

Protocol 36 is to be used under the following circumstances only:

- When the public health authority (or head of government) in your district, state, province, region, or county has officially declared a pandemic flu outbreak/emergency.
- When the EMS authority, system medical director, and the emergency communications center director have authorized its use.
- When a response plan for each of the Protocol 36 Determinant Codes (including the suffix codes) has been pre-approved by the EMS authority and the system medical director.

Protocol 36 will help manage suspected flu patients in a manner that utilizes scarce EMS, hospital, and community health care resources effectively and efficiently during a declared pandemic. Correctly routing flu patients at the first point of contact with the EMS system (911, 999, 000, 112, etc.) will be critical in an emerging outbreak environment.

Surveillance (done prior to Protocol 36 implementation)

Prior to an officially declared pandemic, emergency communications centers may be engaged in flu surveillance activities. The purpose of surveillance is to identify patterns, trends, and geographical clusters of symptoms. Such surveillance may be requested or required by local public health authorities to try to determine if a flu outbreak is occurring in your region. ProQA — the software version of the Medical Priority Dispatch System® (MPDS) — contains a flu surveillance tool specifically for this purpose: the Severe Respiratory Infection (Swine Flu) Symptoms screen. It is accessed by clicking on the “Severe Respiratory Infection (Swine Flu) Symptoms” (V) button on the ProQA toolbar.

This screen — designed and actively updated by the Special CRBN (Chemical, Biological, Radiological, Nuclear) FastTrack Committee within the IAED — provides a set of possible flu symptoms that the EMD can record for patients suspected of having the flu.
Since specific symptoms may change as a particular outbreak spreads and more information is known about the disease, the IAED may rapidly update this screen based on information from various public health organizations such as the Centers for Disease Control and Prevention (CDC), Health Canada, United Kingdom National Health Service (NHS), Australian Department of Health and Ageing, and World Health Organization (WHO). Updates will be posted on the ProQA ftp (file transfer protocol) website for rapid download availability to all ProQA users with a current compatible software version.

Expert data-mining software (such as FirstWatch™) can track special ProQA data in near real-time to detect potential outbreaks within specific geographic regions so emerging patterns and subsequent alerts can be made to the proper public health and governmental authorities.

It is important to note that such surveillance activity is done in advance of an officially announced outbreak—and does not call for the use of Protocol 36 at that point.

Implementing Protocol 36 for a declared pandemic

Modified triage

Should a full-scale pandemic outbreak reach your region, it will rapidly overwhelm the capacity of your emergency medical response system. At the height of the pandemic, EMS resources will be severely depleted due to extreme call load, overload or quarantining of receiving facilities, and a high incidence of EMS workforce illness.

Hospitals will become full. Flu patients may require special treatment—including a response that is different from a standard mobile EMS response provided under non-outbreak conditions. Some patients initially treated by paramedics or ambulance personnel may be left at home. Sicker patients may be transported to designated patient collection points that will serve as makeshift treatment facilities. Other patients may be given a limited amount of care over the phone, with no mobile response from EMS units, due to isolation and quarantine measures—or simply from complete ambulance system depletion.

Protocol 36 will identify potentially infected patients and assign a Determinant Code that accounts for both the patient condition and the degree of system depletion during an escalating crisis. Protocol 36 contains several OMEGA codes. Cases assigned an OMEGA code allow for (but do not require) a non-ambulance referral or resource assignment.

Selection of Protocol 36

Rule 1 means: During an outbreak, Protocol 36 will sort out suspected flu patients from those who have other non-flu related conditions such as emphysema, asthma, congestive heart failure, heart attack, stroke, etc. Therefore, after a pandemic is officially announced, the EMD must always select Protocol 36 when any of the complaints listed in Rule 1 are present. Cases not exhibiting any flu symptoms will be shunted to the correct Chief Complaint through the MPDS interrogation process and assigned a Determinant Code consistent with the patient’s condition (e.g., 6-C-1, 10-D-1, etc.).

Rule 2 means: A patient with the flu will almost always have at least one of the flu symptoms defined on this protocol. During a declared outbreak, one flu symptom present is an indicator the patient is a true flu case. With two flu symptoms present, the EMD may reasonably conclude that the patient has the flu; hence, there is no need to continue the remainder of the specific flu questions. The EMD will move directly to Key Question 11 once two flu symptoms have been identified.

Rule 3 means: Some patients whose Chief Complaint itself is a potential flu symptom (due to their description of the complaint) will not have the flu. Instead they may have other serious underlying conditions such as asthma, heart problems, emphysema, stroke, etc. When no additional flu symptoms are identified in the Key Questions, the EMD must shunt to the correct Chief Complaint protocol using the original complaint description given (i.e., Chest Pain, Breathing Problems, Headache, Sick Person) so these conditions can be properly prioritized and treated.

Rule 4 means: Sometimes patients will take anti-inflammatory drugs such as aspirin, acetaminophen, ibuprofen, etc., to relieve flu symptoms. If the patient reports that he/she had a recent fever that was relieved by such a drug, it is still important to record the existence of the fever (at the time the drug was taken). Always answer the fever question “yes” when the caller reports a recent fever relieved by medication.

Protocol 36 can only work effectively with precise and complete information; 100 percent compliance to the Case Entry and Key Question protocols is imperative in arriving at the correct Determinant Code and response. Cutting corners to save time actually makes the process less effective and may place certain patients at increased risk.

Modified responses during a pandemic

As previously mentioned, EMS responses during a pandemic may be significantly different (reduced) than those under standard operating conditions. Each agency must develop a pre-approved response for every Protocol 36 Determinant Code (including all suffixes) based on the current pandemic level.

Protocol 36 provides several options for down-scaling the response during an escalating crisis

Priority levels

First, the MPDS priority levels in Protocol 36 (OMEGA, ALPHA, BRAVO, CHARLIE, DELTA) have been adjusted to provide for a more aggressive triage of patients with conditions associated with the flu. For example, patients with abnormal breathing and/or chest pain who also have flu symptoms are assigned to a lower priority level than non-flu patients with difficulty breathing and/or chest pain (on other Chief Complaint Protocols).

An OMEGA-level designation always allows for a non-ambulance response with the protocol at any time. This may include transfer of the caller to a designated clini-
cal adviser, such as a registered nurse or nurse practitioner, who will complete a more detailed assessment of the patient/caller and advice over the telephone and treatment instructions to the caller. Certain patients may require isolation or quarantine; this would be determined by the clinical adviser, and the proper home-care or treatment options would be explained to the caller.

Suffix codes
Second, the suffix codes reflect the degree of outbreak severity (and subsequent resource depletion) your system is experiencing at any given time.

There are three suffixes used for determining coding: A, B, and C. These suffixes correspond with the announced numeric severity level of the pandemic outbreak in your system or region. The assigned severity level will depend on several factors, including: the lethality of the flu virus itself, the increase in EMS calls, the degree of EMS responder workforce depletion, and the amount of hospital bed saturation in the local hospitals and emergency departments.

The EMS agency, in consultation with the system Medical Director or Medical Advisory Group and Public Health Authority in your region, will determine (and may modify) the pandemic severity level at any time. Note that the severity level may change from day to day; therefore, the EMD center must be in regular communication with these authorities so that any changes in severity level are recorded and activated accurately within the MPDS.

ProQA will automatically assign the correct suffix (severity level) to the case once the EMD enters the current severity level in the Key Questions. The Key Question will be displayed as an (blue) operator question in ProQA (see below).

The current severity level suffix is always attached to a Determinant Code so that a unique and different response can be assigned for each severity level within that code. For example, a coding of 36-A-1B may receive a different (reduced) response than a 36-A-1A. A coding of 36-C-1C could receive a different (and even more reduced) response than a code of 36-C-1B to reflect the current, increasing degree of system depletion—and, therefore, diminishing level of actual response.

Shown here is a sample case that displays some MPDS determinants in the ProQA software matched with possible example responses for each of the flu severity levels (A, B, C).

NOTE: These are only examples. All actual responses are locally defined.

Responder notification of flu symptoms and infection control
In order to facilitate responders’ correct use of infection control measures, the EMS crew dispatched to the scene (when a locally-determined EMS response is required) will be given the Chief Complaint and Determinant Code during the call notification and unit-dispatch process. It will be at the direction of the local medical control authority (physician Medical Director or medical control board) to provide specific policies, procedures, and protocols for crew protection and infection control during an outbreak. The EMD may (at the direction of local medical and 9-1-1 authorities) provide a detailed responder script for the responding crews. This responder script will typically include the patient’s age, gender, status of consciousness, status of breathing, and Chief Complaint—including the existence of any flu symptoms.

This CDE is adapted from the Special Procedures Briefing, which was designed to give you the information needed to implement at dispatch, correctly triage, and set up potentially decreasing response levels to possible flu patients during a declared pandemic. The entire Special Procedures Briefing can be found in PDF format on the Academy’s website at www.emergencydispatch.org/flu.php. Select “Just in Time Training for Protocol 36: Special Procedures Briefing” under #3. The briefing can be used and distributed for training when preparing for a pandemic flu outbreak.
1. What is the number of the protocol altering EMS responses to certain patients during unusual (outbreak) situations?
   a. Protocol 6 (Breathing Problems)
   b. Protocol 10 (Chest Pain)
   c. Protocol 26 (Sick Person)
   d. Protocol 36 (Pandemic Flu)

2. ProQA—the software version of the Medical Priority Dispatch System—contains a tool specifically for the purpose of flu surveillance activities. What is the name of this tool?
   a. Severe Respiratory Infection (Swine Flu) Symptoms screen
   b. Altered Level of Consciousness screen
   c. Difficulty Speaking Between Breaths screen
   d. Special FastTrack to Response screen

3. Potential outbreak surveillance activity is done in advance of an officially announced outbreak and does not call for the use of Protocol 36 at that point.
   a. true
   b. false

4. During a true flu outbreak, what number of flu symptoms must be present for the EMD to reasonably conclude that the patient has the flu?
   a. one
   b. two
   c. three
   d. four

5. An OMEGA-level designation always allows for a non-ambulance response that may include transfer of the call to a clinical adviser.
   a. true
   b. false

6. What are the three suffixes used to reflect the degree of outbreak severity your system is experiencing at any given time?
   a. X, Y, Z
   b. 4, 5, 6
   c. A, B, C
   d. 3, 2, 1

7. The current severity level suffix is always attached to:
   a. Case Entry.
   b. Post-Arrival Instructions.
   c. a Key Question.
   d. a Determinant Code.

8. Who has the responsibility of providing specific policies, procedures, and protocols for crew protection and infection control during an outbreak?
   a. Dispatcher answering calls during an outbreak
   b. News media
   c. Local medical control authority
   d. Ambulance crew responding to calls

9. Rule 4 of Protocol 36 means:
   a. always answer the fever question "yes" when the caller reports a recent fever relieved by medication.
   b. during an outbreak, Protocol 36 will sort out suspected flu patients from those who have other non-flu related conditions.
   c. some patients whose Chief Complaint is a potential flu symptom (due to their description of the complaint) will not have the flu.
   d. a patient with the flu will almost always have at least one of the flu symptoms defined on this protocol.

10. ProQA will automatically assign the correct suffix (severity level) to the case once the EMD enters the current severity level in the Key Questions.
   a. true
   b. false

In order to receive credit for this quiz you must be certified in the specific discipline it is designated for. To be considered for CDE credit, this answer sheet must be received no later than 06/30/10. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy's CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located to the right and mail it in with your processing fee to receive credit. Please retain your CDE certificate to be submitted to the Academy with your application when you recertify.

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Dispatching Ethics in the Real World. It’s all about being a professional

By Malcolm Woollard

A professional is defined by the Oxford Dictionary as “someone highly skilled.” However, whilst this unquestionably describes the abilities of Emergency Dispatchers (EDs), being part of a profession means much more than this. Professionals typically set rules for membership of their group, and these may be codified in the form of standardized pre-entry criteria educational programs and examinations. They also establish standards of conduct for themselves and their peers, and in the case of EDs, these are represented by the International Academies of Emergency Dispatch® (IAED) Code of Ethics.

Perhaps one of the most important aspects of being a professional is the moral duty to ensure that high standards of conduct, service delivery, and care are always maintained. This aims to protect the public’s interests. Rarely, in order to ensure this, a member of a profession who does not meet the required standards may be barred from its practice by their peers. A professional (and, indeed, a profession) will always put the public’s interests above his or her own and this expectation is made explicit for dispatchers in the IAED’s Ethics Policy.

Ethics

This has been defined as “the branch of philosophy that deals with distinctions between right and wrong.” Whether something is “right” or “wrong” can also be described in terms of its morality and principles. Further, to be “ethical” in the conduct of a profession, one also has to display integrity (“honesty” and “soundness”). Exactly what actions are defined as right or wrong, or good or bad, can only be answered in the context of the society or group making that definition—in other words, this may vary according to the period in history and according to the accepted conduct and expectations of a particular culture. Therefore, the IAED’s Code of Ethics seeks to make these potentially hazy areas explicit for dispatchers.

The Code of Ethics

I remember some time ago walking into a large dispatch center, which I then managed, and seeing a calltaker quite literally banging his head on the desk. He was flushed and the veins in his temples were distended and pulsating. He looked like his head was about to explode. Keeping a safe distance (making sure I was out of splatter range) I asked him what was causing his apparent frustration. It was only when he put his caller on hold that I realized he was processing an emergency call. “I’ve been trying to tell this woman for 20 minutes that she doesn’t need an ambulance!” he
explained. I explained back (now with the veins in my own temples throbbing) that this misunderstanding on the part of the caller would be best resolved by sending her an ambulance—RIGHT NOW.

I am sure the dispatcher meant well—he was trying to protect the precious resources of the over-stretched urban ambulance service that employed us. Having counted to 10 and receiving his side of the story, I concluded that this particular ambulance service could go on employing us, and that we could use this as a learning opportunity.

This dispatcher breached a number of points from the Code of Ethics. Firstly, he wasn’t placing the needs of this particular member of the public above his own. He thought he “needed” to maintain the availability of ambulances to respond to other calls. He also “needed” to make it clear to the caller that she should not waste his time. Most of all he “needed” to win the argument he had started with the caller. The caller thought she needed an ambulance. Whether the caller was right or wrong about the appropriateness of the call, the dispatcher was clearly placing his needs above those of the caller.

All experienced dispatchers and responders can recount hundreds of examples of calls where their ambulance service has been “abused.” However, many EMS systems throughout the world recognize the difficulties and pitfalls inherent to “no-send” policies as there are also many examples of disaster befalling patients when an ambulance has been denied. The rights and wrongs of no send are beyond the scope of this article, but suffice it to say the policy of our agency was to always send in response to an emergency call. Even more significantly, the United Kingdom Department of Health has explicitly stated that this was the case. A dispatcher clearly placing his needs above those of the caller.

A professional will always put the public’s interests above his or her own.

A professional will always put the public’s interests above his or her own. He displayed little integrity, in that he knew the caller was entitled to an emergency ambulance response, but said nothing to indicate that this was the case. At best, this was dishonorable; the less charitable may prefer to describe it as dishonest.

I am also sure that this dispatcher did nothing to “assist in improving the public understanding of emergency dispatching.” This caller would have been left with the impression that the only way to obtain an emergency ambulance was to engage in an unpleasant verbal fencing match with a dispatcher for 20 minutes prior to such a request being conceded to.

This dispatcher’s behavior did nothing (despite his claimed intentions) to “assist in the operation of and enhance the performance of his dispatch system.” Instead, he took at least 10 times longer than normal to process one call. During the time he spent on the phone, his colleagues had to manage an already intense workload without his contribution, placing them under considerable, additional strain. Doubtless the call waiting time increased and callers experienced longer delays before receiving assistance than would have been the case had this EMD acted professionally.

This EMD, in denying the caller her rights and by behaving in an aggressive and abusive manner, did not “maintain the highest standard of personal practice” nor did he maintain the integrity of the IAED.

I did, however, ensure that this dispatcher met the requirements of the second item in the Code of Ethics by providing him with a significant opportunity to “improve his professional knowledge, skill, and competence.”

Putting it into practice

So, as a dispatcher (EMD, EFD, or EPD), do you need to memorize the Code of Ethics and constantly mentally check that you are in compliance with it? Probably not. Most dispatchers are naturally ethical and professional in the conduct of their duties. But to be sure, always listen to your conscience: if it feels wrong, it probably is!

Postscript

The United Kingdom introduced statutory State Registration for its paramedics in 2003. Several of my colleagues have spoken in distressed terms about the Code of Conduct, which every U.K. paramedic will now be measured against. “But this gives loads of protection to the public and little to us!” they agonize. Sounds to me like we’re in danger of becoming a profession.

References

CDE-Quiz Answers to the CDE quiz are found in the article “Dispatching Ethics,” which starts on page 12.

1. Perhaps one of the most important aspects of being a professional is the moral duty to maintain:
   a. high standards of conduct, service delivery, and care.
   b. the right opinion no matter what the customer says.
   c. upper hand in all communications.
   d. an attitude showing who’s in charge.

2. The primary importance of every emergency call rests upon:
   a. the availability of ambulances.
   b. the needs of the caller.
   c. winning the argument.
   d. the amount of time spent with the caller.

3. The dispatcher must always win “the argument.”
   a. true
   b. false

4. The dispatcher’s behavior should assist in the operation of the dispatch system.
   a. true
   b. false

5. The customer is rarely right because the professional knows what’s best.
   a. true
   b. false

6. The United Kingdom Department of Health has explicitly stated that an ambulance must be sent:
   a. in response to every emergency call received.
   b. when the EMS system decides it’s appropriate.
   c. any time the patient demands an ambulance, even if the EMD disagrees.
   d. depending upon the Chief Complaint and destination.

7. A no-send ambulance policy represents a best systems approach since such a policy cuts down on costs and saves the vehicles for real emergencies.
   a. true
   b. false

8. Which of the following groups unanimously adopted the Academy’s Code of Ethics?
   a. Council of Standards
   b. Advisory Board
   c. College of Fellows
   d. Emeritus Board

9. Another word for ethics is:
   a. aptitude.
   b. diligence.
   c. dishonesty.
   d. principles.

Refer to the NAED website for the following question:

10. A violation of the Academy’s Code of Ethics could result in the suspension or termination of certification and recertification.
    a. true
    b. false

In order to receive credit for the quiz you must be certified in any of the three disciplines. To be considered for CDE credit, this answer sheet must be received no later than **06/30/10**. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE certificate to be submitted to the Academy with your application when you recertify.
Two weeks that will change your future*

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“I’ve been involved in this profession for almost 20 years. During that time I’ve attended multiple National and State APCO and NENA Conferences. The CCM course was hands down the BEST learning experience that I have ever experienced. I recommend attending, in fact I plan on having every one of my management staff attend the class.”

— Tom Ling, Johnson County Central Dispatch

Online applications for the 2009 course to be held in Kansas City, MO will begin January 5, 2009. Go to www.emergencydispatch.org or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.

Presented by Fitch & Associates on behalf of NAED

NENA has approved this course as credit toward recertification for the Emergency Number Professional designation.
Taking it Personal. An emergency is never routine for person making the call

By Michael Spath

There are reasons doctors avoid treating their own family members: emotions can interfere with objectivity; stress affects judgment; and so on. What happens when one of our own dials 9-1-1? How do we treat him or her when he or she is the one in the emergency situation? Does the protocol still apply?

I’ve written about making it personal without taking it personally.

Well, recently, things got personal for us at our center in Sunnyvale (Calif.). One of our senior public safety dispatchers called 9-1-1 from his mother’s house. His mom was suffering from severe abdominal pain and she had a large mass swelling at the site of a recent injection.

Compliance to the protocol can feel very awkward when it’s one of our own on the other end of the line. Gathering information from a stressed out responder or dispatcher at the scene can be very difficult. The emotional detachment we usually carry can become uncomfortable; fortunately, the protocol helps us keep an emotional distance while, at the same time, showing our compassion in gathering the information necessary at a critical time of need.

In our case, the EMD who had taken the call said, “I feel weird having to ask you all these questions.”

Our senior’s response, in the face of a very scary situation, was inspiring. “That’s OK,” he said. “Without the questions I wouldn’t remember what I need to.”

Throughout the call, he did remember a lot of the information we needed, volunteering conscious, breathing, and completely alert... but he didn’t remember the entire protocol (who would in that circumstance?!). Thankfully, our EMD was there to help him through the situation — and if things got worse, she could have told him exactly what to do next.

I’m reminded of that little catch phrase we use so often: “So, we’re sure to do it right.” Even if they’ve heard the instructions before, a little reminder is better than none. With emotional stress involved, rational thought becomes more and more difficult. We were there for one of our own last night. Thankfully, it was not a life or death emergency, but it was a call for help — and we were there.

That morning, our senior’s mom went into surgery. The inflammation on her abdomen had grown to softball size. Over the course of the night, while doctors stabilized her condition, the inflammation had grown three times larger. She was apparently bleeding from the internal side of her recent injection. They would be going in to remove the pooled blood, wash away any clots, and try to repair whatever was bleeding.

She was in good hands and had been the entire time — from before the 9-1-1 call to the operating table.

Thank you all for the service you provide for everyone’s family and friends every day — because it’s always personal for someone, even if it’s routine for us. It’s uncomfortable to remember that all the time, but that’s what made this particular 9-1-1 call stand out for us. It was from a member of our family. It is very, very important to keep in mind that the emergency is personal for someone; we are helping someone who could be any of us someday. We are all members of the same family.

At the same time, it’s also important to occasionally remind ourselves of the extraordinary job we do and the excellent service we provide every day. We are there when someone we know — or don’t know — needs us the most.

Thank you.

Michael Spath, ED-Q Instructor
Administrative Senior Public Safety Dispatcher, Sunnyvale DPS
What Difference Does it Make? The reasoning behind certification requirements

Brett:
I am a dispatcher for a large metro emergency communications center that recently introduced MPDS®. The protocol makes sense to me and I believe it will help us better serve the public. My issue is certification. Several of the dispatchers, including myself, have been here at least five years. Why should we have to certify?

Brandon (last name and affiliation withheld on request):
Certification goes beyond the experience and knowledge accumulated during your years spent in the profession. While that is certainly important, the experience does not address the overall benefits certification provides to agencies and the public. I will list a few, each applicable to the protocol you’re using—fire, police, or medical.

Certification provides validation of current skills necessary to use the protocol. Initial certification by NAED® certified instructors provides a sound foundation for protocol use; continued certification ensures that EMDs are up to date with regard to protocol evolution and other areas of Continuing Dispatch Education (CDE) necessary to function in the ever-changing climate of DLS.

Certification also provides limited liability protection through standardization of care and due diligence on the part of the EMD and agency. There is a great deal of controversy surrounding minimal to non-existent standards in EMD and many states are in the process of passing bills to require minimum training and certification.

The Academy strives to meet all of those standards in its certification process. It is far easier to defend a certified EMD in civil court because certification validates a minimum standard. While the Academy is not in a legal position to “require” certification for users of the protocol, it is highly recommended and the Academy is not able to back an EMD or agency in a court of law if the EMD in question is not currently certified.

The monetary argument is a reality but has proven to be a poor excuse in court, or with the public. The cost of certification and 24 hours of CDE every two years is relatively low compared to other costs associated with communications center operations. As Dr. Clawson has been known to state, “The cost of EMD training is often less than the cost of the chair the EMD sits in.”

EMDs are a recognized part of the EMS response chain. Having EMDs practice without current certification is morally akin to sending out uncertified paramedics or EMTs. I would strongly advise current certification for all EMDs using the MPDS. To do otherwise is risky and seriously degrades any commitment to quality patient care and responder safety.

Brett Patterson
NAED Academics & Standards

Greg:
The link between lights and siren response and patient survival is not direct. However, several studies have suggested that the use of lights and sirens saves minimal time. An internal study in St. Petersburg, Fla., compared all lights and siren responses to the complaint of “Stroke—Not Alert or Breathing Normally.” The difference was about 33 seconds. This was an internal study in Pinellas County, Fla., and was not published. A study out of North Carolina published in Annals of Emergency Medicine compared lights and siren transports to COLD duplicates of the transports during the same time and day of week. This study, in a suburban setting, showed an average 42 second difference.

When discussing this with Dr. John M. arler, associate director, Clinical Trials, National Institute of Neurological Disorders and Stroke (NINDS), he suggested that although stroke treatment is time-dependent, the risks associated with HOT responses (accident risk to responders and the public and anxiety risks to patients), did not justify the minimal gain associated with saving only a minute or so when the patient was not in need of time-critical, airway intervention. The Academy believes that stroke is a pre-hospital emergency and should dictate an immediate, ALS-level response. However, since not all pre-hospital emergencies justify a lights and siren response, HOT responses should be reserved for those patients with minute or second critical emergencies (i.e., where the risk of arrest, airway problems, serious hemorrhage, or complicated child-birth are present).

With regard to STEMI patients, potential ACS patients are generally assigned a HOT response not necessarily because of the seconds saved for STEMI treatment, but because of the risk of arrest and second critical advantages of CPR and defibrillation.

With that said, it is not the Academy’s position to dictate local responses; we make general recommendations. For instance, while a CHARLIE-level response is recommended as ALS, each agency is encouraged to study the outcomes of individual determinant descriptors (C-1, C-2, etc.) and allocate according to resource availability and outcomes. For example, an agency may choose to send an ALS unit COLD to a suspected stoke patient who is alert and breathing normally with speech or movement problems but send the same unit HOT for a patient who is not alert or not breathing normally.

The Academy has gathered a considerable amount of cardiac arrest outcome data to assist agencies with this response allocation process; send me an e-mail if you would like further information.

Brett Patterson
NAED Academics & Standards
Centers of Attention. From its beginnings in Utah, the protocol continues to march around the world.

By Heather Darata
Audrey Fraizer

MD Judy Swenson remembers the reaction to Dr. Jeff Clawson’s Medical Priority Dispatch System® (MPDS) when it was introduced into the Salt Lake City Fire Department’s (SLCFD) communications center 30 years ago.

“There was a fair amount of resistance from everybody—dispatchers, fire fighters, administration—but obviously administration thought there was some good in it or they would have not instituted it in the first place,” said Swenson, a SLCFD dispatcher at the time the MPDS was adopted. “Nobody thought that anything good would come out of Salt Lake but it truly did.”

The SLCFD, Dr. Clawson’s hometown fire department, was the testing grounds for the early development of the MPDS, and the first in the world to integrate his standardized medical dispatch system. Its fire department dispatchers were consequently the original batch of trained emergency medical dispatchers (EMDs).

No one anywhere had tried anything like this before giving Dr. Clawson and his supporters the pioneer distinction in promoting pre-hospital medicine starting at the dispatch level. But 30 years ago, few knew about or appreciated his innovative protocol ideas. Public safety had yet to catch his vision about the key role dispatch could play in the chain of life as first, first responders.

Though an emergency medical doctor filling a newly created role as the SLCFD surgeon, Dr. Clawson was a relative outsider to the communications center. He had driven ambulances and even dispatched but his fledgling protocol needed more than his hometown fire department’s seal of approval. It needed to be given a chance on the big stage.

A little perspective

Emergency medical services were still in their infancy 30 years ago when protocol went public in 1979. Only 13 years earlier, in 1966, the National Highway Safety Act (P.L. 89-564) had established national standards for training emergency medical technicians and minimum equipment requirements on ambulances; there was no national single number to call when needing help in an emergency.

By the time Dr. Clawson took over as SLCFD fire surgeon in the late 1970s, ambulances in many parts of the country were dispatched via an answering service that, in turn, paged the paramedics. In the few centers employing dispatchers, training was non-existent and the job of dispatching was often relegated to someone not particularly interested in the position. A little perspective on the horizon, although yet unseen, was a 1975 study coming out of Seattle, Wash., showing that survivability of heart attack victims improves with early intervention of Advanced Life Support (ALS).

The report applied to EMTs and paramedics, those providing ALS on the scene, and not the dispatchers answer-
ing the emergency calls coming into their centers. Dr. C. Clawson and others slowly acclimating to the role EMDs could play had to find a way to apply that same kind of interventional reasoning to their work. The natural place to start was the Salt Lake Valley and, from there, move to other states looking for a pre-hospital care solution.

Something had to break

A major coup d'état, they knew, would be the acceptance by a big center, one that wouldn’t back off from the radical changes proposed in dispatch response. The MPDS had to present as a system showing its potential savings in terms of emergency medical runs, manpower, wear and tear on vehicles, and burnout while, also, proving its ability to help patients during the first critical minutes of their emergency.

California, ho!

A significant nibble west of Utah was through an early acquaintance Dr. C. Clawson made during his efforts to persuade others to at least give protocol a try. Robert M. Mills, then a Stockton (Calif.) Fire Department firefighter/paramedic was no stranger to the responsibility of answering 9-1-1 calls when he enrolled in an EMD course taught near where he worked. Mills neither liked the way he saw others treat dispatchers nor the responsibility that came with the job lacking formal training. He found protocol a solution to his long simmering aggravation.

“There was adoption of it in a central place in California (Stockton) that became the ignitus of the spread throughout the state,” Dr. Clawson said.

Stockton catapulted California into the new era of dispatch; it was just what the protocol needed as way of introduction to the bigger world.

The domino effect

Fred H. Urtado, who was serving as president of United Paramedics of Los Angeles (the city’s paramedic union) and working as a paramedic for the Los Angeles City Fire Department, had just completed a report on the Los Angeles state of EMS with Steve Balentine, a fellow paramedic and a member of the union’s executive board. The late 1970s report affirmed 9-1-1 call complaints they had long circulated and proposed ways to improve the system through phone triaging and basic medical education.

“No body wanted to have anything to do with the report or the priority dispatch protocols Urtado had read about in a 1981 edition of JEMS magazine.

“Hey, this is L.A.,” Urtado recalled was the city’s response. “We’re the big leagues. Salt Lake City should be sending people here to ask us how we do medical dispatching.”

Urtado persisted but it took seven years and a 60 Minutes broadcast in December 1988 highlighting dispatch problems in agencies including those in large cities like Los Angeles that put the ball in his court. The city of three million people depending on a center answering 205,000 EMS calls annually.
Actually adopted the Priority Dispatch System.

From California central, the protocol spread up and down the coast. Today, California stands as one of the heaviest protocol users states, with 187 participating centers. Major centers to adopt protocol during the next decade following Los Angeles’ implementation included the San Jose Fire Department, in 1997, followed later that same year by the San Diego Fire-Rescue communications center.

Both wanted a system prioritizing calls without the hassle of redesigning home-grown models they had used for years.

“We said ‘yeah, you know, what we’ve got is good but what they’ve got is way better,’” said Tom Anglim, currently San Diego Fire-Rescue’s EMD quality improvement manager. “There was no reason other than the fact that we were already doing something that actually looked like questions and we knew that MPC (Medical Priority Consultants, now Priority Dispatch) was leaps and bounds ahead of us.”

Moving south

Protocol skipped its way across the country during the intervening years. At about the same time Hurtado was ready to clinch the interest of Los Angeles, protocol landed its second big fish along the Atlantic coast.

Sue Tolliver arrived in Pinellas County, Fla., at a time when the wheels of dispatch were being set in motion. It was 1986 and the company determining her transfer from the Midwest was bidding on a computer-aided dispatching (CAD) system for the county’s emergency communications center.

Tolliver was familiar with the MPDS from her previous job in Kansas City, Mo., and once her company, Sunstar EM S, was notified of its successful bid and the contract was signed, she was selected as the Pinellas County EMS Director of Communications. She welcomed aboard Joe Ryan, M.D., as Pinellas’ full-time medical director.

Dr. Ryan was a progressive medical director incorporating EMD into his job with the county rather than keeping his distance, which was the direction most medical directors took when it came to emergency dispatch.

“Joe Ryan was among very few doctors that actually looked at communications as part of their role as a medical director,” said Brett Patterson, NAED Academics and Standards Associate and, at that time, a paramedic hired to dispatch for Sunstar.

“Most medical directors for EMS systems worked in ERs and part time they would help write protocols for the field medics.”

Dr. Ryan’s unabashed passion for EMS motivated major medical groups like the National Association of EMS Physicians (NAEMSP) to bring other medical doctors into the EMD fold. Communications centers in Florida following his lead now number 135 licensed protocol users.

“He got a small crowd of these doctors interested in this non-visual medicine and they became staunch supporters,” Patterson said. “They were leaders in the EMD field so all the new docs out there—the ones coming out of school that were joining this organization—were looking to them. Now there’s this whole new culture of thought that ‘yeah, communications is part of our responsibility’.”

But Pinellas County didn’t stop there.

Dr. Ryan created a paramedic fellowship program, selecting 15 medics from the center who could chose between two tracks—clinician or quality improvement.

Patterson, who chose the quality improvement track, later established a program to raise and maintain Pinellas’ protocol compliance. Within about six months scores tripled, from 27 percent to 95 percent.

“We were sort of an epicenter of EMD,” Patterson said. “We didn’t have the dispatchers who were just taking an address and sending an ambulance. They were involved in how the system ran.”

From Florida, protocol branched in directions north, south, east, and west, as did the concept of placing a medical doctor at the helm of communications centers.

Deborah Brown, instructor for Cleveland (Ohio) EM S, remembers a course taken in Florida sparking a change in the way Cleveland’s center operated.

“I brought all the stuff back and put it on my supervisor’s desk,” she said. “Soon after that we were using the system.”

George Chaloupka, now EM S operations commander, said protocol addressed the problems Cleveland was facing at its communications center. While there were general guidelines, there wasn’t anything to help prioritize calls and they were discouraged from providing the center’s version of pre-arrival instructions for fear of lawsuits and a lack of continuity among dispatchers.

“I think Deborah was one of the ones that actually came over here and said that she had found something that would give us a structure to work from instead of everybody doing their own thing,” he said.

Dr. Clawson and Scott Hauert, national director of training at that time, flew into Cleveland with Hauert remaining at the center for several weeks to train during off shifts. Dr. Clawson made periodic visits to provide orientation and executive training.

The center that had adopted the MPDS card in 1991 switched to ProQA® in 1993 and became the world’s second Accredited Center of Excellence (ACE) barely three months after the Albuquerque (N.M.) Fire Department.

Austin-Travis County (Texas) EM S, which implemented the protocol in 1998, has a call volume fast approaching other major cities. Austin is the fourth largest city in Texas and sixteenth in the nation and because the city is located within the center of Travis County, 20 EM S units are...
located within the corporate limits and another seven are strategically positioned within the county. Up to eight communication medics staff the EMS communications center depending on the time of day and the expected workload.

In 1995, the City of Austin EMS Department, Austin Fire Department, and Travis County Emergency Services Department jointly created and funded a full-time medical director to be responsible for all clinical aspects of out-of-hospital emergency care in the city and county.

They hired Edward M. Racht, M.D., who, among his multiple assignments and initiatives, directed emergency communications operations until, in fall 2008, he became the vice president of medical affairs and chief medical officer for Piedmont Newnan Hospital, in Newnan, Ga.

Dr. Racht is a firm believer in the role of the emergency medical dispatcher (EMD) in effective and improved patient outcomes. During his tenure in Texas, the center and NAED participated in several joint emergency dispatch studies and submitted protocol enhancements through the Proposals for Change (PFC) process. In 2008, for example, nearly 700 calls made in response to a one-page commitment, said NAED Associate Director Carlynn Page.

Moving transatlantic

Chris H. Artley-Sharpe, a paramedic for the London Ambulance Service with a background in research, took his training to the task in a study to choose a system meeting National Health Service (NHS) Trust requirements to prioritize emergency calls. The MPDS was among two in the running.

“There was obviously quite a lot of discussion within the organization about which of the systems we should go for,” he said. “I did quite a lot of work going around the country because a number of other services had already started using the systems and learning a bit more about them, which was helpful.”

The result of his investigations put the MPDS in the world’s largest and busiest free ambulance service, covering a geographic area of 620 square miles and a resident and commuter population of more than nine million people.

NAED participated in several joint emergency dispatch studies and submitted protocol enhancements through the Proposals for Change (PFC) process. In 2008, for example, nearly 700 calls made in response to an individual questioning the usefulness of protocol. "My response to him was essentially that it's not nearly as risky as not prioritizing them would be," he said.

The LAS implemented ProQA in 2000 and achieved ACE status in 2002. On July 7, 2005, the MPDS was put to the test in response to the terrorist attacks on London’s public transportation. James Gummett, LAS quality assurance manager, said the center put its catastrophic incident plan in action, placing the lowest priority calls into a non-ambulance response category.

“We were able to do that up to the third tier (of seven tiers) of calls because of our confidence in the way the system worked,” he said.

The response to the crisis was one factor leading to the National Enterprise Maintenance Agreement (NEMA) signed July 25, 2006, in partnership with the Department of Health, Ambulance Trusts, and the International Academies of Emergency Dispatch® (IAED). NEMA established the use of the Advanced Medical Priority Dispatch System® (AMPDS) as the standard for emergency dispatch in the Emergency Dispatch Centres (EDC) and ambulance trusts. Eleven of the country’s 13 ambulance trusts and 24 EDCs have taken up this new agreement.

Where it all began

The SLCFD communications center has traveled a road expanding from a single lane to a superhighway during the past 30 years. Not only is protocol there to help during a personal emergency but it’s also there for larger scale events affecting entire communities. Few living in Salt Lake City two years ago will forget the night of Feb. 12, 2007, when hundreds of calls flooded the police and fire communications centers reporting a lone gunman shooting people at random inside a local shopping mall.

“The protocol we used gave us the voice of authority,” said SLC FD dispatch office shift supervisor Laurie Wilson-Bell in the Sept/Oct 2007 Journal. “We knew exactly what to say to calm them down while awaiting help to arrive.”

Like their Rocky Mountain predecessor, more than 3,000 centers worldwide have integrated a Priority Dispatch System to improve their 9-1-1 response and establish emergency dispatchers as the first, first responders. Their involvement with the National/International Academies of Emergency Dispatch® (NAED/IAED) and the further development of the police, fire, and medical protocols are key to the continued success of everyone. The relationship signifies a two-way commitment, said NAED Associate Director Carlynn Page.

“They are dedicating resources to areas like quality improvement and feedback in the form of the Proposals for Change,” she said. “That helps them improve while providing invaluable assistance to the evolution of protocol.”
Navigator 2009 celebrated a community created by protocol during its 30-year journey, which began in Salt Lake City, Utah, and has since wound its way through communications centers around the world.

The event, held the last week of April in Las Vegas, had all the trappings of the educational experience emergency dispatchers have come to expect plus the glitter of showmanship both on the fabled strip and in the conference center. The event also held an eye toward the future.
“I should have plenty of ideas to try out,” said EMD Kelly Thomas, dispatch supervisor, First Responder EM S, Chico, Calif. “I’m here for the week and it’s just beginning.”

Thomas arrived early, attending the pre-conference session “Overcoming Negativity in the Communications Center” taught by Nancy Banks, supervisor, communications training, Peel Regional Police in Ontario, Canada.

The week ahead not only offered her and the other 1,052 attendees 60 conference classes to choose from but, also, an abundance of keynote talks, award presentations, the displays of 53 vendors in an expansive exhibit hall, and some good old-fashioned fun found poolside and at indoor parties.

Wednesday’s opening session featured a 4-minute song dedicated to 30 years of protocol, composed and played by Dane County (Wis.) Medical Director Dr. Paul Stiegler, and a 33-minute documentary film by the N A E D chronicling the stories of people instrumental in protocol’s development and its climb to international acceptance. EMD Rebecca Sims, from M edStar EM S, Fort Worth, Texas, received the Dispatcher of the Year Award, and in an award new to Navigator, Paul Pepe, M .D., accepted the EM S Innovator of the Year Award from Jeff Clawson, M .D., co-founder of the National Academies of Emergency Dispatch® (N A E D).

Dr. Clawson, who conceived the idea of protocol more than 30 years ago, acknowledged Dr. Pepe, medical director, Dallas (Texas) Metropolitan Medical Response System, for his outstanding contributions to emergency medical services, including medical protocol, during a career spanning nearly four decades. The protocol, Dr. Pepe said, was an innovation developed from paying attention to a job once garnering little respect, even among the public it served.

“What we did in 1984 was innovative because we sat beside the dispatchers for months on end,” he said. “No one had sat in those seats before. It’s because of all of you that we’re here today.”

Brian Dale, battalion chief at Salt Lake City Fire Department (SL CFD) and N A E D Accreditation Board chair, presented Dr. Clawson with a Lifetime of Meaningful Change Award after liberating him on stage with the 1979 version of the SLCFD protocol training manual contained in its original green pocket folder.

Acknowledging Dr. Clawson’s preference to stay out of the limelight, Dale lauded him—albeit briefly—for his three decades of dedication and, in the interest of the green folder, his fascination with items relating to the protocol during its 30-year history.

Twenty years in dispatch has given Lynn Carrol many hats to wear and, at this stage of her career, that means switching them depending on the day.

The variety, however, is the major reason she likes the job with Jefferson County (W. Va.) Emergency Communications.

“I like the job a lot,” she said.

“There’s a lot of variety plus the ability to help people.”

Carrol signed up for two pre-conference courses dealing with personnel issues offered by the National Emergency Number Association (NENA).

Both courses gave her plenty of ideas she can take back to work, particularly in relation to a recent move into a new center.

“My boss signed me up for them,” she said. “And, I’m glad he did.”

Elizabeth Holcombe
Strathcona County Emergency Services
Sherwood Park, Alberta, Canada

A change in management at Strathcona County Emergency Services was all it took for Elizabeth Holcombe to attend her first Navigator conference. The 20-year veteran dispatcher, who will soon become a lieutenant, was able to get a glimpse into sessions covering staffing issues such as aging and personality differences, how to keep dispatchers engaged, and protocol compliance. “We’d like to eventually become an ACE,” she said.

From the way they were laughing and carrying on in the back of the classroom during a mid-afternoon break, you’d think their friendship or, at least, time working together, extended over the years.

But that wasn’t so. The three 9-1-1 professionals had met that morning in the Overcoming Negativity in the Communications Center pre-conference class led by Nancy Banks, ENP.

“I haven’t known them as long,” said Teresa Staley, EMT, supervisor for Morrow County 9-1-1 in Mount Gilead, Ohio.

“The long wait at the airport shuttle made me a few minutes late for class.”

The three laughed. Staley’s sliding into the chair at the back table a few minutes past the 8:30 a.m. start time proved beneficial. The issues she came eager to discuss were similar to those brought by Clarissa Larson, EMD, shift commander, Mesquite (Nev.) Police Department, to her right, and JoAnne Fleming, dispatcher/calltaker, Alberta Health Services, Grande Prairie, Alberta, Canada, to her left. Navigator 2009 was also the first N A E D conference they had ever attended.

“Whether you’re from a large or small center, the issues are the same,” Larson said. “We all want to get along, make sure
“He’s much more comfortable moving forward than looking back,” Dale said. “But as he has always shown, if better is possible, good is not enough.”

Randolph Mantooth—a.k.a. Johnny Gage of the 1970s television show Emergency!—gave EMS a historical perspective with an opening session presentation focusing on emergency medicine from the shifting view of an actor turned EMS advocate.

For many, the hour-long presentation was a walk down television’s memory lane and a reminder about why they entered the EMS profession, even many years after the show went off the air.

“The character inspired career choices,” Mantooth said. “As the face, I get the credit, but you are ones saving lives. I’m not the hero. You’re my hero.”

The Wednesday evening pool party drew few people into the water, although it served as an icebreaker among the three generations of professionals now present in the workforce. The baby boomers through their Generation Y coworkers shared stories about what brought them to the conference as well as the profession.

While it was Johnny Gage who introduced Brant Butte, AMR communications manager in Seattle, Wash., to EMS, it was the adrenaline rush that’s kept him there for more than a decade, including a dozen years on the road and in the field.

“I was very excited to run calls,” said Butte, who became a paramedic straight out of college with a degree in physical education. “The old timers everybody does a great job, and live by the golden rule.”

You may think you’re the only center having problems with some negative attitudes, Staley added.

“You come here and find that isn’t so,” Staley said. “It may be due to different situations, but negative attitudes affect everyone.”

Fleming attributed a current, although anticipated temporary, drop in morale to a master plan consolidating the former 32 centers to three centers in Alberta.

“This is a massive change for us in a relatively short time,” she said. “It’s a huge issue. Overwhelming. I volunteered to come here to learn what we can do about it.”

The same objective applied to Staley and Larson.

It’s not about changing the world.

“This is about coming to a job where you can make a difference,” Larson said. “When negativity gets in the way, we need to do something about it.”

Ron Shiner
Sunstar
Pinellas County, Fla.

Even after a span of several years since he last attended Navigator, Ron Shiner knew exactly what he was looking for. As the chief training officer at Sunstar in charge of maintaining reaccreditation, the center’s Q program, and training, Shiner was after information about training, morale, and behavior—topics he found in abundance during the three days of formal classroom presentations. Shiner, who began as a paramedic in the 1980s before later making the move into the comm. center as a dispatcher, also said Navigator gave him the opportunity to expand his network of peers.

U.S. Army Dispatch Supervisor Heather Decker, of Fort Riley, Kan., has never had a big problem with supervising dispatchers older than her generation. She has heard the far end of the baby boomer range may be harder to train and she does understand the resentment an older person may have given her, someone a generation younger, place of authority. The differences, however, are something she has learned to appreciate. “Our generation is more technology based and we don’t want to slow down,” she said. “But I also value the experience baby boomers offer. A lot of them have been doing this for a long time. That’s something I really respect.” Decker is pursuing a degree in emergency management and homeland security, a career path brought to the forefront by world events of the past decade.

“[Dr. Clawson] is much more comfortable moving forward than looking back. But as he has always shown, if better is possible, good is not enough.”

–Brian Dale
Holly Raan
Pro Transport 1
Cotati, Calif.

As a first-time Navigator attendee and a clinical support coordinator at her center, Holly Raan paid special attention to the training classes. She’s working on developing training materials since those at her center would benefit from the extra help after having adopted the medical protocols less than a year ago. The conference has been a worthwhile experience for her. “It’s been a great help understanding where our call center’s at, where it’s coming from.”

Caltaker Carol Hayes and Dispatcher Trish Robinson obviously have scant issue over the core and work value generational differences research attempts to define. “It hasn’t been all difficult,” Robinson said. “As long as Trish is willing to bend, we get along just fine.” The sarcasm might be a reason the two traveled together to Navigator 2009 from their home state of Alaska. Not only were they the lucky two in the rotation of choosing who goes to the conference, but they also came at an optimal time considering the recent hire of five people under the age of 22 (Generation Y), and a center with an age range between 21 and 62. “We have a lot of information to hand over to our boss,” said Hayes, who, like Robinson, said she “loved” the pre-conference sessions. “This is not a job for everyone,” Robinson said. “But when I meet people who say this is what they want to do, I’m quick to tell them about what I like about the job. I don’t want anything negative they might hear to get in the way of what they want to do.”

Annette Sharp
Detroit Police Department
Detroit, Mich.

Annette Sharp decided to concentrate heavily on the police track since she doesn’t deal with other types of calls on the job. She’s been a dispatcher for 12 years but this was her first shot at experiencing Navigator. At the end of the conference, she came away with a greater understanding of what fire, EMS, and 9-1-1 personnel do. Sharp enjoyed the chance to spend time mingling outside of the classroom as well as collecting information from exhibits and classrooms. “I do have some ideas to take back.”

Movie stars, showgirls, and Michael Jackson and Madonna impersonators aside, the real showstopper was the demonstration of police, fire, and medical protocols in action on stage Thursday morning, the second day of Navigator. Actors “experiencing” cardiac arrest, a home fire, and the kidnapping of a boy from a playground kept the house entertained in their one-act renditions of emergency calls that the real stars—dispatchers—answer as the first link in the EMS chain of command.

The live action was followed by on stage recognition of the Accredited Center of Excellence (ACE) recipients and Communications Center Managers (CCM) course graduates.

The ACE certificate is now displayed in 131 communications centers, from the first center ever certified (the Albuquerque Fire Department Communications Center in New Mexico, 1993) to the newest additions to the list of fire accredited centers (Harford County (Md.) Division of Emergency Operations and Sarasota County (Fla.) Public Safety Communications, both in April 2009).

A agency representatives accepting the ACE award had more than the certificate in common, as indicated by Julie Baker, Mayo Clinic Medical Transport/Emergency Communications (Rochester, Minn.).

“I don’t want to sugarcoat this for anyone, because it’s not easy,” she said. “It was work, as everyone would agree. Every gray hair I gave me, though, was worth it when I saw the look of pride on everyone’s faces when the acceptance letter arrived.”

“[Navigator] opened my eyes to how we affect people everyday, not only at the communications center but in our personal lives, also.” —Lois Clancy
Kelly Thomas straddles the fence between Generation X and Generation Y. It’s not an easy task balancing the two generations—despite her age and its relevance to the events influencing core and work values—but added to the mix are the baby boomers under her direct supervision. “That’s the reason I came to the conference,” she said. “I want to learn how to become a better supervisor.” Thomas’ eight years in EMS is a combination of nonemergency transport, dispatching, and emergency transport. She credits the range of her experience and training as the reason she was selected as supervisor. By the end of an eight-hour course exploring the differences among generations, she was looking forward to bringing the information back to the center. “I should have plenty of ideas to try out,” she said. “I’m here for the week and it’s just beginning.”

Melissa Cotnoir Emergency Communications Center Nashville, Tenn.
Melissa Cotnoir enjoyed the ability to pick and choose classes from the various tracks. Since this was her first time attending the conference after starting as a dispatcher with her department 13 years ago, she picked sessions that she was interested in, covering a variety of areas including some of the management offerings. “It really broadens your view.” However, Cotnoir is not looking to give up dispatching any time soon. “Right now I really enjoy what I do. I don’t want to give up dispatching because it’s my passion.”

Barry Coleman EMSA/Paramedics Plus Oklahoma City, Okla.
Since this wasn’t Barry Coleman’s first Navigator, the communications quality improvement supervisor for the western division of EMSA knew what to expect from attending last year’s conference in Baltimore, Md. Coleman worked in the field for several years before making the switch to the comm. center nearly nine years ago. After sitting in on sessions as well as having an opportunity to network, Coleman said he was able to come away with “a different spin on things.”

Twenty-one of the 26 graduates of the CCM course took center stage, led by Jaci Fox, quality assurance coordinator for the Medicine Hat 9-1-1 Regional Communications Centre in Alberta, Canada. The class, she said, provided a collaborative approach in resolving a multitude of issues common to all centers.

Morris Tamanaha, of the Regional Dispatch Center in Pearl Harbor, Hawaii, said CCM reinforced information accumulated during his career and introduced him to a network of people from centers of all sizes. “The camaraderie, or network, will be something we will maintain for the rest of our careers,” he said. “Large or small, we all have the same issues.”

The last day of conference had attendees scrambling to 75-minute sessions beginning at 8 a.m. sharp and ending minutes before the closing luncheon. Similar to the previous two days, classes held on the last day of Navigator focused on the fire, police, and medical protocol and topics devoted to leadership, management operations, and special interests.

NAED President Scott Freitag opened the closing luncheon with a tribute to Bill Boehly and Bill Lloyd, both of whom made contributions integral to the advancement of EMS, the Academy, and protocol. The two men died just months apart this year from cancer.

Dr. Clawson presented Fred Hurtado with the annual Leadership Award, acknowledging his lifetime commitment to EMS and the NAED. In his most recent roles, Hurtado, who was key to bringing protocol to the Los Angeles (Calif.) Fire Department, is an EMS/EMD consultant for EMS Systems Solutions, LLC, and was recently appointed to the NAED Board of Curriculum. The two have known each for almost the life of the protocol.

“If I actually told you everything that Fred has done regarding EMS and EMD then we’d be here all afternoon,” Dr. Clawson said.

The conference concluded with an update on the new Protocol 36 (Pandemic Flu), which determines whether a patient initially presenting with certain Chief Complaints is a likely flu patient or a non-infected patient. The Protocol, released during Navigator, coincided with the global outbreak of the swine flu.

For Lois Clancy, public service communicator officer II, Montgomery County (Texas) Hospital District, Navigator represented a unique opportunity to attend a conference devoted to her career of 20 years. “This is my first conference and I loved it,” she said. “Absolutely loved it. It opened my eyes to how we affect people everyday, not only at the communications center but in our personal lives, also.”
People Everywhere. Navigator 2009 combined education, networking, and celebration during its weeklong stay ringside the Las Vegas strip of never-ending entertainment. The annual conference gives dispatchers from communications centers around the world the opportunity to exchange ideas and laughs while attending everything from classes, exhibits, talks, poolside parties, and even golf tournaments. Pictures here include Conrad Fivaz, standing by his hole-in-one made during the Bill Boehly Memorial Golf Tournament; Randolph Mantooth, speaking at the mic during his keynote presentation highlighting his days as TV’s Emergency! star Johnny Gage and his current EMS advocacy; and Dr. Jeff Clawson, accepting the Lifetime of Meaningful Change Award for the many years he has devoted to EMS and his trademark emergency fire, police, and medical protocol.

Johnny on the Spot. *Emergency!* still making a splash 30 years later

He was the heartthrob of millions of admiring fans and the reason behind many making EMS their profession. He was the guy recommending injection of Ringer’s Lactate solution for the critically injured patient lying inside the ambulance rushing to Rampart Hospital along the streets of Los Angeles.

He was Johnny Gage (Randolph Mantooth), the TV star who made it through five seasons in a prime time slot and, since going off the air, a career promoting emergency services at conferences including Navigator 2009.

“Emergency! and MASH were my shows, and it was a marvelous experience seeing him (Mantooth) on stage,” said Lois Clancy, public service communications officer II, Montgomery County (Texas) Hospital District.

Mantooth held his audience spellbound for more than an hour as a conference keynote with his tales of America’s once most recognizable firefighters and paramedics and the people responsible for making the prime time melodrama authentic. The show coincided with the widespread establishment of emergency medical services paramedic programs across North America in the mid and late 1970s.
Swing Town. Highflying ball rides the winds of celebrity

Chaos could best describe the sight near Hole Number Six at the Legacy Golf Course in Las Vegas.

A club was thrown, a scream was heard, and then came the thunder of feet stampeding onto the green. The air was electric, etching into memories a scene that people will still talk about in years to come.

“It was really quite nice,” according to Conrad Fivaz, M.D., medical director, Priority Solutions, U.K. Operations. “I knew it was close.”

And, apparently, closer than he had imagined.

Fivaz hit his first-ever hole-in-one on the par three, 129 yard sixth hole, during the Bill Bohmly Memorial Golf Tournament held on Tuesday morning, April 28, at Navigator 2009. He hit the ball into the wind using a pitching wedge and watched it fly over the flag.

“From there, it went right in,” he said.

Fivaz’s teammates in the Captain’s Choice—Ken Winward, Pam Stewart, and Howard Blaser—were every bit as stunned, ecstatic, and energized in that order. The foursome went on to finish first against a field of six other teams.

Golf is a sport Fivaz picked up almost 20 years ago while in medical school. He found the serenity of the greens a perfect escape from the rigors of study, much the same as he does nowadays when taking a break from his demanding job.

Fivaz has averaged about 30 games a year over the past 19, bringing the total number of holes close to 11,000 shot on 18-hole courses. Although the odds vary by course and experience, his chance at making the hole-in-one was something around 4,000 or 8,000 to one.

Travels with Dorothy. She’s a Navigator regular

Dorothy PDP gets around, and her travels cover so many years, that it’s a wonder the young miss shows little sign of slowing down. Dorothy is a pig—a Priority Dispatch Pig (the “PDP”)—ferried into the annual Navigator conference for the past decade compliments of anyone willing to accept the assignment. Once the week draws to a close, fans say their goodbyes and the plucky pig departs the same way she arrives, though courtesy of a traveler different than the previous and heading somewhere on the map determined quite by chance.

“I just have to make sure she goes with someone who’s sure to make it back the next year,” said Annette Jordan, Quality Improvement supervisor for the Memphis (Tenn.) Fire Communications Bureau.

In other words, mention you’re coming back and the pig may be yours for the taking.

Dorothy, of course, is not a real pig, at least as she looks to those outside the tight group of two-legged buddies accumulated since her debut at Navigator 1999 held in San Diego. She’s a plush pink lady always ready to go where destiny points, which is certainly no reflection of her character.

This year, Mark Rector, director, Priority Dispatch Corp., Consulting Services, left with Dorothy, who looked quite fetching in the red dress bearing Navigator pins collected during her decade of travel. Rector plans to plunk her in a place of distinction—a shelf overlooking his desk—as a daily reminder that he better remember to pack her in his bags next year.

“I’m honored,” said Rector, who works out of the Salt Lake City, Utah, PDC offices. “I was supposed to take her last year but our schedules didn’t cross.”

“J”
An Obvious Choice.

Dispatcher of the Year knew the profession was right for her.

E

MD Rebecca Sims has the type of background that might not come as a surprise to those familiar with the dispatch profession.

Prior to joining MedStar in Fort Worth, Texas, two years ago, Sims worked at both an emergency and a long-term shelter for abused women. She was EMT certified and a volunteer with MedStar. Sims attended college to become a nurse and has plans of going back someday so she has the “framed piece of paper” to hang on a wall. But don’t expect to hear about her changing jobs once she earns that degree.

“I love what I do,” Sims said. “Dispatch is my real calling. That may sound odd but I do think that happens in this profession.”

Calling or not, the award Sims received at Navigator 2009 no doubt says more about her than the B.S.N. credential ever could. The profession goes to the heart of her personality and a calling, if you will, so strong that it figured into her selection as NAED Dispatcher of the Year.

MedStar QA Supervisor Melissa Allen said Sims is a natural at dispatch and, beyond that, she exemplifies what the agency looks for in its new recruits.

“Becca is awesome,” Allen said. “Her heart is at the center of what she does. To me, she’s a career dispatcher. She’s a part of the new generation entering the profession.”

Not only did Sims respond remarkably well to a call involving a premature delivery and prolapsed cord, submitted as part of her nomination, but she had also achieved the highest compliance score among the center’s EMDs. The distinction earned a scholarship to Navigator along with coworker Jolene Quigg, who achieved the highest compliance score among the center’s supervisors.

Sims fully grasped the significance of the award once arriving at Navigator and meeting hundreds like her, determined to make a profession out of helping others. The networking, or camaraderie, is a major reason Allen said they offer the scholarships.

“The call submitted as part of the nomination demonstrated Sims’ command of EMD protocol. The patient was the passenger in a car parked at an instant care center following premature labor and upon learning an unsettling truth: her baby was delivering 13 weeks prior to the due date. The cord presented before the caller was able to get the passenger out of the car and the subsequent call to 9-1-1 had Sims assisting while they awaited the arrival of paramedics.

“That’s the amazing part,” said Center Director Tammy O’berst. “The patient was at a care center but it was Becca’s instructions giving the child every benefit at life.”

Eager to share in the Navigator and Vegas excitement, Sims brought along her parents, grandmother, sister, niece, and two friends. As far as the award trophy is concerned, don’t expect to find it collecting dust on a mantle in her home.

“I’ll bring it to the center,” she said. “This is an award meant for everyone, and not only me.”
The word “surprise” popped into Fred Hurtado’s mind when he heard his name called to receive the Jeff Clawson Leadership Award.

The only inkling Hurtado had that he might be the recipient was the fact that Dr. Clawson gave a rundown of some of the individual’s accomplishments prior to announcing the name of the recipient.

“Once he got far enough into it where the profile started to fit, I thought ‘uh oh,’” Hurtado said.

The Academy was able to keep the “surprise” hush-hush, a particularly arduous task since Hurtado was already scheduled to give two presentations at Navigator 2009.

Hurtado and Dr. Clawson met almost 25 years ago, several years after the article “Dispatch Priority Training: Strengthening the Weak Link,” detailing Dr. Clawson’s EMD program, was published in JEMS, catching Hurtado’s attention.

“I first met Fred at a convention similar to this,” Dr. Clawson recalled. “It was International Firefighters in Los Angeles in 1985 and I was cruising the exhibit hall and noticed that there was one exhibit that really wasn’t an exhibit—it was more like a card table with a couple of guys sitting behind it—and I stopped and introduced myself and there was Fred. We struck up a conversation about dispatch stuff. He actually had some codes and some data there at the table that he gave me, which I still have. The rest is history.”

The always self-effacing Hurtado thanked Dr. Clawson and then, turning to his audience, said he was proud to be part of the EMS army.

“Rallying the Troops.”

Fred Hurtado urges audience to keep EMS army advancing

“The dream lives on, the struggle continues,” he said. “Let’s keep on moving kids.”

Hurtado has a passion for public safety and said it has been a privilege for him to be involved.

“The recognition is nice but the positive feedback comes from the people that you educate who in turn go out and touch the lives of millions of people,” Hurtado said. “That’s really what it’s about. So I think that any time any individual is recognized, the recognition isn’t yours and yours alone. It’s a function of all the mentors you’ve had, and all the associates and colleagues you’ve interacted with. For those of us who train or teach, it’s a function of the feedback that you get from dispatchers.”

Highlights of Hurtado’s career include: former paramedic, Vietnam vet, fire department employee, new member of the Board of Curriculum, television news guest (60 Minutes), union president for United Paramedics of Los Angeles, and EMD instructor for many years having likely taught more classes than anyone other than Brian Dale and Brett Patterson.

“If I actually told you everything that Fred has done regarding EMS and EMD then we’d be here all afternoon,” Dr. Clawson said.

Hurtado chose 911 CARES to receive the $500 the NAED contributes to the award recipient’s charity of choice. 911 CARES is a nonprofit agency founded by Public Safety Training Consultants to provide assistance to emergency communications professionals during their times of personal crisis.
Sitting Ducks.

Lack of regulations puts dispatch in vulnerable position

BY AUDREY FRAIZER

Sometimes, emergency dispatchers must feel like the brunt of all that might be wrong with 9-1-1. A mishap or complication preventing timely or adequate response comes right back to the place where the process started, no matter the link or links in the chain that may be responsible.

The dispatcher caught in the media frenzy is scrutinized and, for the most part, made to look incompetent or indifferent to the cry for help because of that one call, despite the literally hundreds and thousands of positive outcome calls during his or her career. The result: the loss of a dedicated employee singled out because of the media’s push for sensational news, or the potential loss of qualified dispatchers from the fear of public humiliation in the case something does go wrong.

Part of the problem may be a lack of directive; the dispatcher is the first link in the chain of survival, yet it is a profession with few regulations. All other medical professionals are regulated by states for the purpose of assuring the public that those providing the service are properly trained and supervised.

Why doesn’t the same sort of legislative safeguards hold true for emergency dispatchers?
After all, this is a job that takes far more than lessons in phone etiquette or the ability to sit still for a 12-hour shift. The modern Emergency Medical, Fire, and Police Dispatcher (EMD, EFD, EPD) must be able to quickly identify the seriousness of the problem, dispatch the appropriate response, and provide life-sustaining medical instructions to the caller when necessary.

These are skills best not left to chance, without the benefit of training and certification. The nature of the work and the consequent public responsibility demand the highest standards of accountability.

Yet, according to our research, only slightly more than half of the states have regulations for certification, training, and continuing education. Many states have something in place but preliminary research shows little consistency nationally. States without regulations are leaving their communications centers wide open to litigation. When something does go wrong, dispatchers become the focus of debate for reasons outside their control—nothing to support their efforts save, perhaps, for the training required to operate the equipment.

The National Academies of Emergency Dispatch® (NAED) believes that every state needs regulations for certification, training, and continuing education. For that reason, there is a model statute available on the NAED website. The essential elements are listed here, further down in the story. For more information, go to www.emergencydispatch.org and click on resources.

The map accompanying this story summarizes legislation available from the states and pertaining specifically to emergency medical, fire, or police dispatching. The summaries give the state’s requirements, such as whether certification is required and if the state mandates the use of protocol. We do not vouch for the effectiveness or relevance of any state’s legislation. Our research was preliminary in nature and compiled without judgment of a program’s merit. If we’ve missed what your state is doing or given an inaccurate summary, let us know and we’ll include that information, and any updates, in future issues of The Journal.

NAED model

The basic enabling legislation areas are:

- Purpose
- Authority and Responsibility
- Recognition
- Definitions

(continued on page 36)
Montana—A plan in accordance to an enhanced 9-1-1 system, including training (basic telecommunicator and use of written or automated EMD protocols)

Nevada—Requirements for EMD certification

New Hampshire—EMD licensing requirements

New Jersey—Certification through a 24-hour EMD training course approved by the state

New Mexico—Dispatch training requirements

North Carolina—EMD educational program requirements

North Dakota—EMD curriculum requirements

Oregon—Criteria for the use of two-way communications and procedures for summoning and dispatching aid

Pennsylvania—Requires EMD protocols at all communications centers

Tennessee—Requirements for dispatch training

Utah—Coordination of a statewide emergency medical communications system, including dispatch centers

Virginia—Statewide emergency medical care system to improve dispatching, including EMD training, and center accreditation

West Virginia—Mandatory criminal background check to act as director of an emergency dispatch center and 40-hour training program for dispatchers within one year of hire

No matter which Maryland county Public Service Answering Point (PSAP) receives a 9-1-1 call involving a medical emergency, you’ll get the same method of response.

Protocol.

The call process is standard; it’s consistent and across the board, said Gordon Deans, executive director, Maryland Emergency Number Systems Board (ENSB).

“A process depending on the person answering the phone, without something in place, is sort of like rolling the dice,” he said. “You don’t want that. Protocol gives you the sense you’re doing things right.”

Maryland’s Emergency Medical Service (EMS) dispatchers must be EMD licensed and recognized as an EMD by a state-approved EMD program. They must also demonstrate competence in medical protocols.

Although communications centers directors can use a protocol system of their choosing, as long as it meets approved standards, the ENSB offers funding up to the level of Priority Dispatch System™ products. Only two centers have selected alternative systems for their medical calls. The ENSB is now working toward full adoption of the fire and police protocols.

A standard system has taken some convincing, at least for the current push for statewide use of fire and police protocols.

The EMD protocol was adopted as part of the state’s standard for incident management. It’s written into law. The ENSB has taken on the task for statewide use of the fire and police protocols and—in their drive—are finding that acceptance boils down to the same reasons EMD protocol has become such an important asset to communications centers.

“You talk about nationally accepted standards and you see eyes light up,” he said. “People in the communications centers want things to go well. They’re overjoyed when there’s a system or process for handling the liability issues.”

The ENSB training subcommittee put together a plan that shows local administrators the value of the protocol. They brought

(continued on page 37)
Ducks
(continued from page 34)

Within the area of authority and responsibility lie the 13 essential elements requiring regulations by the states. These are:

1. Certification of EM Ds, EFDs, and EPDs, and their agencies
2. Recertification of EM Ds, EFDs, and EPDs, and their agencies
3. Training and EM D, EFD, and EPD curriculum standards
4. Instructor standards
5. Continuing Dispatch Education standards
6. Approval of the Emergency Medical (police, fire) Dispatch Priority Reference System protocols selected by the agency
7. Required use of an approved protocol reference system
8. Compliance standards for the protocol reference system used
9. Quality assurance (including random case review and performance reporting)
10. Program governing standards for policies and procedures
11. Medical direction and oversight
12. Prevention of misrepresentation
13. Revocation and suspension of certification

Within the area of recognition lie five essential elements the state should address. These are:

1. Certification programs
2. Recertification programs
3. Continuing Dispatch Education programs
4. Instructor programs
5. Accreditation programs

Within the area of definitions, the following should be addressed within the legislation or within the section describing administrative rules: advanced life support provider, continuing dispatch education, compliance to protocol, department, dispatch life support (DLS), emergency medical dispatcher (EMD), emergency fire dispatcher (EFD), emergency police dispatcher (EPD), Pre-arrival Instructions, Post-arrival Instructions, quality assurance and improvement program, vehicle response mode, and vehicle response configuration.

For more information, or for assistance in creating or improving your state’s dispatch legislation, contact NAED Associate Director Carlynn Page.

Tragic Inspiration.
Grieving families turn to advocacy following death of loved one

Nathan Lee believed 9-1-1 was a perfect system for getting emergency help in case his family ever needed it. He also believed there was a standard process every communications center followed.

"Most people do," he said. "But not me. Not anymore."

While Lee doesn’t hesitate to credit the good work that many emergency dispatchers do provide, the two communications centers contacted the day his wife Denise was abducted and murdered gave woefully inadequate responses.

And now he’s set on doing something about it.

In March 2008, two months after Denise’s murder, Nathan and Sean Lowery established the Denise Amber Lee Foundation. It is dedicated to improving operations at emergency centers nationally to make sure they are well staffed with trained personnel and have all the equipment necessary to perform their jobs as well as humanly possible.

Nathan and his father Mark Lee said the foundation’s creation does not represent an indictment of the profession. Rather, the foundation symbolizes their approach for driving change in public policy. The many they’ve met since his wife’s murder agree with their policy initiative once they realize they’re not out “to get them.”

“The biggest struggle is making sure they understand that I want to help,” Nathan said. “It’s the system that needs changing. There needs to be uniformity in the way calls are answered.”

System failure

Nathan’s view of the 9-1-1 system changed forever on Jan. 17, 2008, when his wife Denise was abducted from their home in North Port, a city in west coastal Florida, and murdered. Her body was found two days later in a shallow grave in a remote section of the city. The suspect, Michael Lee King, was scheduled for trial in March.

The sensational case made national headlines because of the horrific nature of the crime—the suspect was a stranger to the family and Denise was abducted while home with her two children, then two years old and six months. The two boys were found in their bedroom at 3:20 that afternoon when Nathan returned home from work. He immediately called police to report his wife missing.

Even more disturbing surrounding the circumstances of the murder was the lack of response to 9-1-1 calls made to two communications centers while Denise was still alive. One call came from Denise using the suspect’s cell phone and another from motorist Janet Kowalski, who called 9-1-1 to report what appeared to be a child screaming and pounding on the window of a blue or green Camaro.

Mark Lee said the mistakes that occurred the day Denise was kidnapped emphasize the need for improvement.

“That night in that call center they had to let some people go home early for fear of overtime; they were having some phone issues and other things,” he said. “That is what we are really trying to prevent from happening again, that way there is never another 9-1-1 call that doesn’t receive the correct response.”

The two dispatchers answering the calls were later suspended without pay for failing to send patrol units to respond to the critical call about a possible abduction in progress. They were also handed six months of disciplinary probation and spent 12 hours in remedial training.
Legislative initiative

Call mismanagement led Nathan and Charlotte County Sheriff’s Office Sgt. Rick Goff, Denise’s father, to make an impassioned plea in support of legislation regarding the certification and training of Florida’s emergency dispatchers. Gov. Charlie Crist signed the measure in May 2008; its effective date was Oct. 1, 2008.

“The hose who were there to oppose the measure never got up to talk,” Mark Lee said. “It was a very emotional speech on the behalf of Denise.”

Their story was so compelling that the legislation became known as the Denise Amber Lee Act. The bill’s beginning, however, dates back before Denise’s death to proposals for dispatch certification introduced in both the Florida Senate and House.

The rule, added to Florida’s Medical Telecommunications and Transportation Act, has all the makings for legislation putting dispatchers at the same level of qualification as other emergency service workers.

In the Name of Denise. Nathan Lee has devoted his life to the cause of emergency dispatch since the murder of his wife Denise Amber Lee last year in North Port, Fla.

With one major exception.

The certification and training outlined in section 401.465 are not required; it’s optional and up to each county’s discretion. While other sections in the law—such as those applying to paramedics and emergency medical technicians—include words such as “must” and “required” when it comes to licensure, the language applying to dispatchers simply states that a person “who desires” certification or recertification “may apply” to the department

(Department of Health). The act establishes criteria for training dispatchers but without funding and mandates, it might never happen in many sections of the state.

Mark Lee said the foundation, among others, is out to change that.

“Many came forward during the process to sponsor bills making training mandatory,” he said. “Public sentiment is pushing in the same direction.”

A problem, of course, is funding for a mandatory training program, especially during the current economic crisis. Mark Lee, however, points to the funding available through E9-1-1 legislation.

“It has to be done,” he said. “If human error does happen but when the error results in the death of one of our citizens, it’s unacceptable.”

Proposed legislation that would create a mandatory curriculum of training of public safety dispatchers failed to win support during this year’s (2009) session. Still standing is the voluntary training program, a proposal that would make certification mandatory by Oct. 12, 2012, and a pledge to bring the training legislation back to Florida lawmakers next time around.

“Legislation is a slow-moving process,” said Mark Lee, who talked about his disappointment over the state’s failure to pass a training requirement and a proposed certification requirement that wouldn’t go into effect for another three years.

The only consolation Mark Lee finds is the time element.

“It gives us until next year to tweak the proposal,” he said.

The Lee and Goff families would most likely prefer to talk about something other than the events surrounding that tragic day in January 2008. But, as Mark Lee said, they continue to tell Denise’s story for the good of any person who may someday need the assistance of emergency services.

“This is a total learning experience,” he said. “We were a normal, happy family until this happened but our loss pushes us to get something positive done.”

Nathan said it’s something Denise would want them to do.

“Shed would want me to fix what’s wrong so no one else would get hurt like she did,” he said.

PROTECTION

(continued from page 35)

in NAED representatives to dispel misconceptions, such as the time a list of questions could add to response time, and to emphasize quality assurance and its effect on calltaking.

“The end result is a better quality call,” he said. “We have to convince them that protocol would get them the information necessary for an efficient and timely response.”

A pilot program testing fire and police protocol in four counties provided a valuable lesson in effective communication, Deans said. He shared the following tips for those who want to effect change on the local, state, and national levels:

Local

- Prepare a plan explaining exactly what you want to accomplish and how your recommendations will accomplish the goals
- Once you get buy-in from the various stakeholders, appoint a liaison who will maintain contact; provide updates and progress reports before being asked
- Invest in a quality assurance program; you want an objective approach to evaluating call processing and in a deliverable format
- Develop good relationships with local media; getting the word out when good things happen can only work in your favor

State and National

- When talking with state and national legislators, identify clearly your subject of interest (in this case, regulations governing emergency dispatch)
- State why you are concerned about the topic and how the issue affects the public
- Share personal experience (tell a story about a CPR save or helping people leave a burning building)
- Put thoughts into your own words (if sending a letter or e-mail, be original—too many nearly identical messages may look as if you’re part of a pressure campaign)
- Establish an ongoing relationship (become a name your representative remembers)
- Get involved in the legislative process (attend meetings and give testimony at public hearings set up to gather information about emergency dispatch)
- Make sure you do your homework about the issue and follow-up when asked for more information
- Keep others apprised of what you’re doing and work together to get the message heard by many
- Finally, don’t give up; most legislation takes more than one session.
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Website offers tools to teach public about 9-1-1

A web-based public safety toolkit designed to teach communities how to use 9-1-1 effectively and promote 9-1-1 education can be downloaded for local distribution at www.intergraph.com/publicsafety/toolkit.aspx. The software data company Intergraph produced the kit in partnership with the National Academies of Emergency Dispatch® (NAED), 9-1-1 Industry Alliance, Association of Public-Safety Communications Officers (APCO), E9-1-1 Institute, National Association of State 911 Administrators (NASA), and National Emergency Number Association (NENA).

The kit contains:
• A citizens’ guide for requesting emergency services
• A design template for a magnet with quick reference tips for calling 9-1-1 (created to fit on a standard-sized refrigerator magnet)

Jerry Overton changes lanes in public safety

Jerry Overton is taking his public safety message across the country. The long-time director of the Richmond Ambulance Authority (RAA) is leaving the East Coast city-operated EMS system to continue his career as president and chief executive officer of West Coast-based Road Safety International Inc.

Overton, who’s leaving RAA after 19 years, will remain entrenched in public safety, though shifting his message to the voice of safety inside ambulances around the world. Road Safety International Inc. is the developer of a “black box” monitoring system used in emergency vehicles and driver safety programs. The system collects real time data and in increasingly louder tones alerts the driver when the ambulance is exceeding parameters of safe operation.

The RAA has been using the device in its ambulances since 1993.

The monitoring and instant feedback system has significantly reduced accidents related to excessive speed or other indicators of unsafe driving in emergency response, according to Road Safety International Inc. Founder Larry Selditz.

“We’re not trying to make medics look like the little old lady from Pasadena,” he said. “But medics tend to get into an adrenaline rush. They’re thinking of a lot of things because of what they’re approaching. The device keeps the medic focused, making sure they get to the scene in a safe and responsible manner.”

Overton has found that the device also cuts down on the cost and downtime associated with preventive maintenance.

“There’s less wear and tear on the vehicle,” he said.

The “black box” device is in line with studies showing that the speed associated with immediate response is more often a hindrance than a lifesaver in EMS. Numerous studies have shown that emergency medical vehicle collisions (EMVCs) due to excessive speed are the cause of injury, death, property damage, and, consequently, significant delays in transporting patients to the hospital.

For example, according to the results of a study published in the April 2, 2003, edition of JAMA (Journal of the American Medical Association), during 1991-2000, 300 fatal crashes occurred involving occupied ambulances, resulting in the deaths of 82 ambulance occupants and 275 occupants of other vehicles and pedestrians. The 300 crashes involved a total of 816 ambulance occupants. The majority of ambulance crashes occurred during emergency use. (SL Proudfoot, NT Romano, MS, TG Bobick, Ph.D., PH Moore, Div of Safety Research, National Institute for Occupational Safety and Health, CDC. Ambulance Crash-Related Injuries Among Emergency Medical Services Workers—United States, 1991-2002)

Overton, who has long been a proponent of the National Academies of Emergency Dispatch® (NAED) protocol system, said the move offers multiple challenges while keeping him in the front lines of emergency response, patient care, and their related technologies.

“I’m very excited about the change,” he said. “This gives me another way to contribute to public safety.”
911 Lifeline proves vital link in dispatch

The 911 Lifeline website is just what emergency dispatchers wanted. Or, at least, it seems that way.

Michael Wallach founded 911 Lifeline in April 2006 as an online forum for telecommunicators and related professionals. Within months, he doubled the features to meet the requests of a growing audience and added a website to support a national membership organization.

Today’s members have access to all sorts of information such as recorded interviews with 9-1-1 professionals, project consultation, and peer written and reviewed articles. He also provides the public with access to the same chat rooms and forums as members to enhance their understanding of the profession.

Wallach expected the life span of the website to surpass the average length of 44 to 75 days most sites endure, considering all the site has to offer. The higher than average return rate to join the forums and blogs lets him know the site does provide what he set out to do—create a space that serves as the voice and face of 9-1-1 communications.

The online research library has become the hit of dispatch.

The popularity really shouldn’t surprise Wallach. He has spent literally hundreds of hours gathering information for the library and he’s organized the material by topic. His advisory team represents a range of 9-1-1 expertise, which adds to the breadth of resources available.

With things going so well, Wallach naturally plans site enhancements. Once 501C (nonprofit) status is achieved, he will add online courses and he wants to encourage making donations toward dispatch education scholarships.

The future looks bright, he said. “This is turning out even better than I had anticipated,” Wallach said. “We’re recognized. People know they can come to the site and find it all.”

Seven’s the lucky number

The U.K.’s Emergency Call Prioritisation Advisory Group (ECPAG) has granted its seventh consecutive approval to the Advanced Medical Priority Dispatch System® (AMPS). ECPAG is an independent committee of clinical experts responsible for advising the Department of Health on issues relating to categorization of emergency calls, chaired by Peter Bradley, the U.K. Department of Health national ambulance adviser and chief key roles in implementing EMD Quality Assurance programs at their agencies.

The Denco Area 9-1-1 District (Texas) Board of Directors established the scholarship program nine years ago in honor of Dr. Groff, a primary care physician who served on the Denco board from 1992 until his death in August 2000. The living memorial commemorates his interest in bringing professional quality EMD training to telecommunicators within the district.

Denco Area 9-1-1 District Training and Education Manager Patty Cross said the conference energizes the dispatchers. As part of the bargain, they incorporate something about what they learned at the conference in a training exercise available to others in the Denco system.

“I see a lot of enthusiasm when people come back,” said Cross, who has worked at Denco for the past 19 years. “For many, it’s a chance to re-energize.”

Denco Area 9-1-1 District was created through voter referendum in 1987 to establish an enhanced 9-1-1 telephone service for the citizens of Denton County and all of the City of Carrollton. In fiscal year 2008, Denco 9-1-1 maintained the addresses and routing databases to deliver 309,721 calls to the 11 Public Safety Answering Points that it serves.

Good attitude and protocol compliance net trip to Vegas

Positive personalities coupled with compliance to the MPDS® protocols landed two Texans from the Denco Area 9-1-1 District in colorful downtown Las Vegas for Navigator 2009.

Stacy Inscore, Denton County Sheriff’s Office 9-1-1 telecommunicator, and Jack Cottongame, Highland Village Police Dept. communications manager, received the Dr. Allen Groff EMD scholarships based on requirements looking at everything from job performance to overall attitude. In addition to achieving high compliance scores, Inscore and Cottongame played two key roles in implementing EMD Quality Assurance programs at their agencies.

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executive of the London Ambulance Service. EC PAG’s latest approval—a signature of excellence in the 999 environment—came after extensive review of v12 codes recently released by the International Academies of Emergency Dispatch® (IAED).

Centers in virtually every U.K. Ambulance Trust rely on the AMPDS for its safe, patient-centered method. The hundreds of millions of callers during the past 30 years the protocol has been in use have received the best options and advice from trained and certified emergency medical dispatchers (EMDs). In 2002, the London Ambulance Service became the world’s largest Accredited Center of Excellence (ACE).

Kickoff generates lots of interest

A national coalition organized to promote technology-based networks among communications centers nationally filled an office space and its phone lines during its recent kickoff meeting.

The Advanced Emergency Communications (AEC) Coalition, the next generation of the advocacy group COMCARE, plans to focus on policymaking through an alliance of national, state, and local organizations, including FirstWatch, the American Ambulance Association (AAA), the Emergency Nurses Association, the National Association of EMS Managers, and the National Academies of Emergency Dispatch® (NAED).

Together, the diverse members of AEC will “develop and improve upon lifesaving services, procedures, training sessions, and tools that maximize value for emergency responders and health care providers,” according to the organization’s website. Issues the coalition proposes to tackle include incorporating electronic medical records into first response, mobile security devices, dispatch education and training, and other topics as they relate to the delivery of 9-1-1 communications.

Telematics—the blending of computers and wireless telecommunications technologies to improve information sharing over vast networks—will be chief among its concerns as was its predecessor COMCARE. However,

RECOGNITION

Early retirement leaves those left behind reeling

W insett’s 38 years of public safety service in Livingston County included two firsts—he was the first emergency program manager and the first 9-1-1 director.

Pollock began working in the 9-1-1 industry in 1991 and after retiring from the Michigan State Police he went to work for Livingston County for 10 years as its first assistant 9-1-1 director.

The two were the team behind organizing a centralized center from the ground up, which meant the nuts and bolts of remodeling the existing center, installing equipment and infrastructure, and shouldering administrative jobs such as balancing budgets, scheduling, and filling out the paperwork.

“That was Dick W insett and Bruce Pollock who put that whole thing together from scratch,” Arbic said. “They literally were a one-two punch for Livingston County. I can’t overstate the loss of talent.”

As part of their remodeling plan, the two top administrators put their office only one door down from the core of dispatch operations. It was a door, Arbic said, seldom closed to what was happening on the floor.

“W insett came in every morning and reviewed activity reports from the previous 24 hours,” Arbic said. “When things occurred over the weekend, he insisted that the staff call him at home and keep him informed.”

But it’s not only their “know-how” and hands-on dedication the center will miss. There is also their mastery of networking. Pollock and W insett knew everything and everyone—at least it seemed that way—including area politicians, county officials, and township supervisors. They also had a major say in selecting the people running the dispatch center.

“The things they did for this county during that time frame from when the center started until today were tremendous,” Arbic said. “We’re doing the very best that we can but wow, that’s a lot to try to pick up.”
AEC Chair Richard Taylor cautioned it certainly won’t be the only priority.

“What data is of importance to emergency response, from the communications center up to the PSAP, remains an issue and an important one,” Taylor said. “We want to go broader. We don’t want to pigeonhole.”

For the past 10 years the COMCARE Emergency Response Alliance has been a voice of advocacy for improving emergency communications and promoting “end-to-end interoperability.” In 2008, the COMCARE Board voted to reorganize and approached the Washington, D.C., consulting firm e-Copernicus to help establish a broader-reaching organization to continue COMCARE’s work.

For more information, go to the AEC website at http://aeccolalition.org.

Trauma triage protocol revised

The Centers for Disease Control and Prevention (CDC) is testing a revised field trauma triage protocol with pre-hospital and emergency medicine groups. The recommendations designed to standardize decision-making at the injury scene also offer guidance on new technologies such as vehicle crash notification systems, which alert local emergency services that an accident has occurred and automatically summon assistance.

Other key revisions include:
- Recommendations for the right place and right time to best use crucial emergency care resources
- Vehicle crash damage criteria to help determine which patients may require care at a trauma center

A 36-member panel representing emergency medical services, emergency medicine, trauma surgery, and public health revised this field triage decision scheme originally developed by the American College of Surgeons Committee on Trauma.

The CDC convened the panel with support from the National Highway Traffic Safety Administration (NHTSA). CDC-supported research shows that the overall risk of death was 25 percent lower when care was provided at a Level 1 trauma center than when it was provided at a non-trauma center.

More information about the decision triage is available from the CDC at http://www.cdc.gov/fieldtriage/.

Potential litigation threatens E911 mandate

Recent litigation asserting virtually unlimited patent rights in any location-based technology service could threaten or, at the very least, put a hold on the ability of wireless carriers to comply with national mandates.

It’s a possibility that doesn’t sit well with telecommunication advocates. Their concern is not only over costly litigation defense but, also, the subsequent delay in providing the technology to locate E911 callers using wireless devices (cell phones).

“I imagine a future filled with dozens of such cases against you, your customers, and the vendor members of associations,” said Kim Robert Scovill, senior director, Legal and Governmental Affairs for Telecommunications Systems Inc. in Annapolis, Md. “Even the threat of litigation has a chilling effect on the innovation of location-based services.”

Snowstorm no excuse to skip awards celebration

Jeffrey Edwards thought a major snowstorm in the forecast might keep him away from an awards ceremony he figured would add yet another letter of commendation to his already acclamation heavy personnel file.

“I told the sheriff the weather may keep me from attending,” said Edwards, a sergeant and senior communications officer with the Ontario County (N.Y.) Sheriff’s Department. “I was basically told I would be there.”

The commendation turned out to be a much bigger deal than Edwards had anticipated. He was honored as Ontario County’s deputy of the year, a prize now sharing the same shelf as the communicator of the year award he received several months later from the New York State Sheriffs’ Association Institute.

“It’s been a good year,” Edwards said, although a bit humbling for a guy who got into a public service career 20 years ago for anything but the attention.

Or the money, he is quick to add.

“It’s hard to be the one selected since everybody works together,” he said. “We’re a team, performing a service.”

The extra tasks Edwards takes on set him apart, at least according to the citation describing his contributions to emergency communications.

The sheriffs’ association noted Edwards as a master instructor for the Finger Lakes Law Enforcement Academy, where his class load includes a two-week, basic dispatcher course. He oversees the heavy personnel file.

Instructor Development course as well as the Communication Training Officer course. Edwards is also involved in the New York State Sheriffs’ Association 911 Accreditation program and he designed and maintains the Ontario County Sheriff Department’s website.

“I do a bunch of extraneous things,” he said. “I need the variety.”

Edwards, of Canandaigua, Texas, started at the 9-1-1 center in 1993. Over the years, he has aided in the delivery of babies and among his most memorable calls, he led emergency crews to a man who had fallen 80 feet to the ground from a railroad trestle during a snowmobile outing. The man survived. Edwards is now the graveyard shift supervisor, where he oversees five to six dispatchers during the busiest time of the day.
The Federal Communications Commission (FCC) requires wireless carriers to implement Enhanced 911 services, including progressively more accurate location-based services. The mandate is part of the Wireless Communications and Public Safety Act of 1999 (9-1-1 Act), established to improve public safety through a nationwide, seamless communications infrastructure for emergency services.

To offset the potential disruption in meeting the FCC E911 regulation, advocates asked Congress for legislation that protects carriers against lawsuits claiming unlimited patents rights in any location-based technology services. The E911 provision was added to patent reform legislation that moved from the Senate Judiciary Committee to the full Senate in April 2009.

Revisions to patent law haven’t been confined just to the emergency services industry. A variety of interest groups had pushed for more than six years for legislation that would deter frivolous lawsuits and limit damages.

The amended patent law took effect in May 2009 and the provision relating to E911 services applied to any unsettled compensation claim filed in the United States Court of Federal Claims, beginning with the date Jan. 1, 2007.

EMS training offers hands-on approach to response role

The Center for Domestic Preparedness (CDP) offers a three-day EMS course preparing all emergency responders for the effects of chemical and biological agents—including radiation and explosives injuries.

The course gives responders the opportunity to reinforce the EMS course triage and decontamination procedures while in an authentic toxic nerve agent environment. The course includes training at the Chemical, Ordnance, Biological and Radiological Training Facility (COBRA TF) in Anniston, Ala.

The EMS course has been part of CDP training courses for the past four years. Each class can accommodate 40 responders.

Michael Montgomery, an EMT dispatcher from Oklahoma City, Okla., found the course particularly relevant to emergency communications.

The National Emergency Number Association (NENA) has recommended the adoption of standardized call-processing protocols for use by emergency communications processing centers. While NENA does not endorse any specific brand of protocol, the association bases its recommendation on what the National Academies of Emergency Dispatch® (NAED) has believed all along: call-processing protocol is the most effective way to ensure the highest standard of care for both the public and emergency responders.

NENA’s protocol model, posted on its website in March 2009, cites the benefits of protocol use as well as the cost factors involved with implementation and a suggested quality assurance process. Typical costs listed include purchase of a protocol system, training, certification, public education, and recurring costs such as software licensing and maintenance agreements. There are also recommendations to develop targeted continuing dispatch education programs and a feedback loop to keep dispatchers aware of their performance.

The model is a voluntary standard developed by a team with representatives from several organizations, including the NAED.

They wanted to say something about structured calltaking, and hadn’t,” said Priority Dispatch Corp.’s (PDC) Consultant Greg Scott, who with PDC Consultant Eric Parry drafted the proposal the committee subsequently approved. “They wanted something out there showing people how to take calls, along with the elements involved in the type of training needed.”

Parry and Scott drafted the model recommendation for NENA not only because of their NAED affiliation but, also, because of the leadership role they want NENA to take in call processing.

“There’s no drought on the number of bungled calls,” said Parry. NENA Education Advisory Board Chair. “We need this and NENA has to be the one out front in support of federally mandated standards.”

The recommended protocol standards are available from the NENA website at http://www.nena.org/standards/operations/emergency-call-processing. The link brings you to a summary of the protocol. While you’re at it, check out NENA’s redesigned website. The new look makes it easier to find the latest in 9-1-1 news and information, including EMS guidance in swine flu, meeting notices, and business and industry updates.
Making a Joyful Sound. Baby’s first cry was welcome music to Louisiana dispatcher

EMD Tricia Bellis thought field response during Hurricane Katrina would be the apex of her emergency services career. At least that was until baby Veronica entered her life from one state over. Veronica is the second child for Karla and David Gross. The family’s home in Gautier, Miss., is not exactly a stone’s throw from Acadian Ambulance in Lafayette, La., where Bellis works as a dispatcher. The two locations are separated by several hundred miles, although that’s nothing compared to the distance that day separating Karla from her husband.

David is part of a construction brigade for the U.S. Navy and was serving in Iraq the day his second daughter was born. They had done the math prior to his departure and, consequently, scheduled backup in the form of Karla’s mother, Hilda Aguilar, and sister, Jael Castro.

The drama started shortly after midnight. Gross’ water broke, signaling an immediate departure to the hospital at Keesler Air Force Base in Gulfport, La. Before they got to the door, Gross went into heavy labor, precipitating a call that led to Acadian Ambulance, which covers the county in Mississippi where the Gross family lives.

Bellis said everything sounded so calm, and it remained that way throughout the 10 minutes she stayed on the line, up until the time paramedics walked into the house.

“It’s almost hard to imagine,” Bellis said. “You’d never know a baby was on the way from listening to them. They sounded so calm and it all happened so quickly.”

Gross had taken the phone and was relaying the birthing Pre-Arrival Instructions in Spanish to her mother. She was translating from English at the same time she was delivering her baby. Veronica was born after the second contraction and Bellis was privy to the sound she said trumps the elation she felt from offering assistance to victims of Hurricane Katrina.

“I thought nothing could top what I saw there, until I heard the baby cry,” she said.
The feeling was absolutely incredible."

Two weeks later Bellis had the opportunity to meet Karla, Veronica, and big sister 15-month-old Hannah during a trip made in honor of the event.

"She didn't let the baby go," said Julie Mahfouz, the Acadian Ambulance public relations and marketing supervisor who arranged the introductions. "Dispatchers rarely get to do the entire birth so I wanted to make this an occasion."

Gross and her mom were no less delighted with the way things happened.

"The feeling was absolutely incredible," said Julie Gross and her mom were no less delighted with the way things happened. "Mom now brags about being here to help," Gross said. "No one believes her until she shows them the pictures of her newborn granddaughter."

The same goes for dad, who gets a steady stream of pictures of his newborn daughter over the Internet; he listened to the recorded audio of her birth, compliments of Acdian Ambulance.

"I've held the baby up to the phone so he can hear her," Gross said. "He gets emotional. We'll never be able to thank Tricia enough for her help."

Repeat After Me: Persistence moves caller from fear to confidence

The title of Lamaze coach wasn't part of the job description EMD Stacey Fralish signed on to when she was hired three years ago by the Outagamie County (Wis.) Sheriff's Department Communications Center.

But it was a title she figured might apply someday.

"Dispatchers know that every call can be an emergency," said Sgt. Barbara J. Scheppf, EMD coordinator/quality assurance chair and E911 supervisor. "It's always in the back of your mind that this could go really good or really bad in an instant."

For Fralish, the instant came at 3:23 p.m. on Jan. 7, 2009. An obviously distraught woman was calling from her home in rural Outagamie County. She was alone and her baby was on its way.

In a moment's time, Fralish became the Lamaze coach, doctor, and the only one who could help, Scheppf said.

Fralish also became an expert on repetitive persistence.

"Usually when you hear screams like that, it's not a good thing," Fralish said. "Although the pain was understandable, I had to keep telling her to stop screaming long enough to get her information. Once we got to the instructions, I kept using repetitive persistence to keep her focused on what she should be doing, and that really seemed to help."

The baby delivered in less than four minutes from the start of the call. But when there was no cry right away, Fralish patiently instructed the mother on what to do next. After what seemed like an eternity, the infant's cry could be heard over the phone prior to the ambulance's arrival. Fralish knew there were still steps to take to make sure both mom and baby were O.K. before relaxing.

The Pre-Arrival Instructions were an asset, Fralish said.

"I felt confident that the medical protocol was going to help me," she said. "The only time I got really worried was when mom kept saying she was going to pass out. She was alone, so if she would have passed out, I wouldn't have been able to help her or the baby."

Fralish received a stork pin and an outstanding service certificate for her actions to assist the 23-year-old first-time mother in delivering her baby.

"Stacey did an excellent job," Scheppf said. "Her kind, confident, and understanding demeanor was crucial in the delivery of a healthy baby boy."

Fralish is happy to have been part of an event heralding the arrival of someone into the world.

"As medical dispatchers, we are a part of seeing people leave this world, so I was happy to be a part of someone entering this world," she said. "A unique part of our job is being able to help deliver a baby, and yet keep our hands clean the whole time."

This was Fralish's first delivery and with this recent addition, the Outagamie County Sheriff's Department Communications Center has aided in the delivery of 10 babies—three girls and seven boys—since 1995.

Listen to a Pin Drop: Emergency responders wait in silent anticipation

The room was so quiet that the crowd gathering around Calgary Public Safety Communications EMD Roisin M. Comish could hear the click of the keys on her keyboard. The air held every word.

"There must have been 20 people listening," said EMD Janice Chalmers, who stood poised in anticipation of what was about to happen. "Everyone was silent, listening to what she was doing."

The event—two years ago—was a pivotal day for Calgary Public Safety Communications. By the time it was over, the
A game of solitaire on the computer may be better than a hot bath to augment labor. At least, so it seems for Teresa Haupert of Boca Raton, Fla.

Haupert was awakened close to 4 a.m. on March 29 from irregular pains she figured were an indication of the baby to come but not at that hour. She slipped out of bed, hoping not to disturb the sleep of husband Kenn Haupert, and crept to the computer to play a game of solitaire to while away the contractions.

The baby was not keen on her attempts to extend his father’s rest. The contractions escalated during the hour Teresa spent at the computer, and shortly after 5 a.m. her frantic cries from the adjoining room jostled Haupert from his slumber.

He grabbed the phone, and from the background noise Boca Raton 9-1-1 EMD Jessica Sullivan could guess the assistance he was seeking as soon as she picked up the phone.

“My wife is having a baby right NOW,” an obviously panicked Haupert shouted into the receiver.

Haupert wasn’t exaggerating. Baby Justin arrived within one minute of the call as Sullivan dispatched a fire-rescue crew to the house. By the time they arrived, a clean and dry towel had been wrapped around Justin, and the shoelace that had kept dad’s shoe tied was now clenching the baby’s umbilical cord closed.

“I can’t believe it, that it happened so fast,” Haupert said during the call, before paramedics made it to their door. “Why did she have only two contractions?”

“Sometimes it just happens that quick,” Sullivan said. “She may have had them during the night without realizing it.”

Paramedics transported mom and baby to Boca Raton Community Hospital, where they spent the day before returning home bearing a certificate listing Kenn as both father and assistant at delivery.

While this wasn’t Sullivan’s first delivery call, it was the first time she heard a baby she had helped deliver let out the welcome to the world cry. Sullivan received a letter of commendation citing her calming influence from Boca Raton Police Chief Dan Alexander and the good feeling that comes from a call well delivered.

“It was great,” Sullivan said. “A very amazing call.”

Playing for Time. Mom’s hand at solitaire fails to postpone baby

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**Name:** Jessica Sullivan

**Comm. Center:** Boca Raton Police and Fire Rescue Communications Center

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Roisin McComish

M McComish, on the other hand, remembers feeling all but calm and controlled during the seven-minute call.

“I was a deer in the headlight once it was over,” she said. “I had to step outside. My nerves were shattered.”

The two dispatchers played the tape over and over that day for those who were there during the call and others who stopped by the center once hearing about the sensational twin birth.

“It made us feel so great about being an EMS dispatcher,” Chalmers said. “We went home that day with smiles on our faces, satisfied a good job was done and empowering the next shift for their day of challenges.”

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Article was submitted by Michael O’Neil, division chief, Boca Raton Police and Fire Rescue Communications Center.

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Jessica Sullivan

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Article was submitted by EMD Janice Chalmers.
Tense Seconds.
Ruptured cord adds alarm to already anxious situation

Name: Joan MacPherson
Comm. Center: Medicine Hat Regional 911 Communications Centre

The early morning call to the Medicine Hat Regional 911 Communications Centre in Alberta, Canada, was almost over before EMD Joan MacPherson began—at least when it comes to a speedy delivery.

“Everything happened so fast,” said Colleen Bachewich, Operations and Quality Assurance coordinator. “Maybe 30 seconds at the most.”

The speed of delivery, however, did not stem the crisis. Moments after the baby was delivered, the frantic parent reported a “broken” cord. The umbilical cord had ruptured at the time of delivery for reasons unknown to MacPherson. Although this was her first experience with this type of complication, she knew the baby could die from blood loss without immediate intervention.

MacPherson rapidly turned to the instructions for a ruptured cord and told the caller to clench the bleeding area of the cord and squeeze it tightly for one minute. Once the bleeding had stopped, the caller tied one string above the rupture and another string below. It was about this time that the ambulance arrived.

“What a relief that was,” MacPherson said. “They had trouble finding the place so I wasn’t sure how long it was going to take them.”

This was the first call the center had received involving a birth complicated by a ruptured umbilical cord, Bachewich said. “Complications are always scary, especially when they involve a birth,” she said.

Never a Dull Moment. Baby times two plus accidental choking make day to remember

Cheektowaga (N.Y.) Police Department 911 Emergency Communications Center dispatchers field so many calls during any given shift that it’s not unusual for them to forget the details of any one call, no matter how dire the situation.

Just ask EMD Edward Dean.

The 20-year veteran of the busy center in north central Erie County routinely answers 60 to 70 calls per eight-hour shift from an area that includes an international airport, shopping malls, business parks, railroad yards, and the usual trappings of densely populated residential communities. So, why would he remember exactly what happened one day, three days after Christmas, nearly six months after the date?

Well, when was the last time you delivered twins and applied the Heimlich maneuver for a choking victim in the space of a morning, while also bracing for calls anticipated from an approaching winter storm?

“We were jamming,” Dean said. The baby call that came shortly after first shift started on Dec. 28, 2008, had Dean calming the sister of an expectant mom with contractions progressing so quickly that a trip to the hospital was out of the question. Dean switched to the Pre-Arrival Instructions (PAIs) for childbirth and once he heard the newborn crying figured the hard part was over.

“I thought everything was fine until she said another one was coming,” he said. “I took a deep breath and said ‘OK. Let’s get ready for the next one’.”

Dean repeated the PAIs and paramedics arrived moments later to find mom and sister cradling the newborns. He disconnected the call.

The morning shift didn’t let up from there. Dean was nearly halfway through his day when the second major crisis came in. A male was choking from what appeared to be a severe blockage.

“The caller was starting to panic,” Dean said. “It wasn’t dislodging and all I could do was have her keep the Heimlich going.”

Dean’s persistence paid off. Although he does not recall what had caused the choking, it was out and the victim was breathing by the time paramedics arrived.

“It’s not every day something like this happens,” said Paul Hockwater, director of the communications center. “Ed’s use of the PAIs and his constant reassurance provided a good outcome for everyone.”

Dean, who is past fire chief for the volunteer Pine Hill Hose Company, was honored for his assistance to the new mom and choking victim at the annual Cheektowaga Police Department Awards Banquet held in March 2009.
Textbook Example. Man follows dispatcher’s instructions to the letter following car birth

Name: K.C. Tull
Comm. Center: Sussex County Emergency Operations Center, Del.

The child delivery call K.C. Tull answered during the morning hours of Sept. 6, 2008, is a textbook example of how things should go thanks to a cooperative dad following every step in the dispatcher’s instructions.

The caller was driving his wife to the hospital, when he was forced to pull over to acknowledge the whims of his soon-to-be-born baby.

The father called 9-1-1 and reached Tull, a Sussex County (Del.) Emergency Operations Center shift supervisor, who stayed on the line providing post-delivery instructions while waiting the several minutes for responders to arrive.

"He went right along with me the whole way," Tull said. "I mean, didn’t miss a beat. Bless his heart he was a huffing and a puffing trying to get his shoestring out of his shoe to tie the umbilical cord off with."

Tull had the man find something to wrap the baby in for warmth, and he kept tabs on the mother’s condition.

"Mom was calm; she wasn’t bouncing off the walls," he said. "I was checking with him to find out from her on anything remotely close to the afterbirth so that way I could tell him what to do with that next. That was the only thing we didn’t get to."

The keys to the call’s success—mother and child were fine—was the caller doing precisely what Tull told him and his continuous dialogue to keep Tull in the loop.

"He explained what he was doing, along with [explaining to his wife] why I was giving him the instructions," Tull said. "That way, she didn’t freak out wondering what in the world he was doing with a shoestring when we came to that part."

While Tull has taken other childbirth calls, none stand out like this one does. The delivery went just like he had learned and practiced although without a baby, when he took the EMD course.

"It was probably one of the better calls I’ve actually ever taken in a situation like that," he said. "In the 13 years that I’ve been here that guy did a tremendous job. He was very calm, cool, and collected for the most part. I could tell he was very stressed what was going on, but he did everything and then some of what I asked him to do."
"I was at the edge of my chair the whole time thinking there was only a certain amount of time I would be able to help."

The baby survived and was as healthy after the cardiac attack as she was before. Buzbee later heard the cause was a bacterial infection. She has yet to meet the family, although the parents were the ones initiating recognition from both the Mobile Fire-Rescue Department and council members.

"Maybe once this is more in the past, we'll have that opportunity," she said.

Buzbee had been on the job for three years when the call came in but nothing, she said, prepares you for a call like that. This was the first time she'd given instructions for infant CPR and the first time she was still on the phone to hear a positive response from the person she was assisting. In this case, she heard the baby crying.

The positive outcome only reaffirms Buzbee's career choice and her dedication to helping people, even the ones she will never meet.

"When something like this comes along, it makes you re-evaluate why you do this, the good things dispatchers do," she said. "Knowing I was there to help save this child's life is a tremendous boost in my life, also."

Unforgettable Call

We welcome your touching or hair-raising dispatch story involving an extraordinary or otherwise unusual call. Don't just think tragic circumstances. Our readers also value stories describing funny situations—your discretion is appreciated.

Real Life

Submit a story about something you think your peers may want to read about. Maybe your center has held a fundraiser for a charitable cause or maybe someone at your center has achieved something outside of work you'd like to share. You can also send us a suggestion and we'll do the follow up and story.

Dispatch in Action, Dispatch Frontline

Send us stories highlighting how protocol helped in an emergency, such as providing the Pre-Arrival Instructions to follow in case of sudden cardiac arrest, house fire, or some other incident involving dispatch and the fire, police, or medical protocols.

How to Submit

It's easy. You can either send us an article (500 words or less) or you can send us a story idea and we'll follow up. In either case, include your full name, the name of your communications center, and your contact information (e-mail and phone number). Send everything to Audrey.Fraizer@emergencydispatch.org. We will contact you.
Former EMD Robert Keddington remembers the birth of his 29-year-old daughter Jaime like it was yesterday.

But, in this case, it wasn't a situation easily lost to memory.

Jaime entered this world from the front seat of a Ford Pinto curbside at Salt Lake City (Utah) Fire Department Station #12 following her dad's mad dash steering the subcompact 75 miles per hour from a suburb some 15 miles away.

"I remember that day all too well," said Keddington, now the principal of Park Elementary School in the city of Spanish Fork, about 50 miles south of Salt Lake City. "I had to act fast."

The emergency medical protocols were still in their infancy (no pun intended) when the childbirth and delivery Pre-Arrival Instructions (PAIs) would have truly come in handy for Robert and Linda Keddington, then the parents of four children and one on the way. It was shortly after 6 a.m. on Wednesday, April 2, 1980, and the former EMD for the Salt Lake City Fire Department (SLCFD) hadn't liked the look on Linda's face 30 minutes earlier when she was standing in the family's living room. Contractions five minutes in duration were coming two minutes apart.

"I grabbed the children and took them over to the neighbors," Keddington said.

From there, it was getting Linda into the car for a trip to the hospital—the same one where they had gone earlier only to be sent home with a verdict of false labor.

"It wasn't a good thing for me when my wife said the baby was coming."

–Robert Keddington

They ran out and Zimmerman crawled into the Pinto with Mrs. Keddington to deliver the baby in 35-degree weather. Higgs waited in the heated ambulance ready to whisk mom and baby to nearby Holy Cross Hospital. Jaime's delivery took all of two minutes.
Linda later claimed her husband was more nervous than she was that morning. But, then again, she had other distractions such as maneuvering about in the front seat of a Pinto to deliver the 8-pound, 13-ounce girl the newspaper story described as “quite chubby, with a little bit of hair.”

Robert said Linda considers Jaime’s birth the best of her eventual seven deliveries, contrary to his recollection of his mad dash along the Salt Lake corridor.

“It wasn’t a good thing for me when my wife said the baby was coming,” he said. “That wasn’t something I wanted to hear.”

Jaime, who turned 29 in April 2009, is the mother of four children. Her husband Spencer Taylor is in the U.S. Army and scheduled to serve his third tour of duty in Iraq. The fire station where they stopped—144 West 700 South—has been since converted into a podiatry center. The Sisters of the Holy Cross ran the hospital where Jaime was taken to until 1994. It is now a regional center with more than 500 physicians on staff.

Keddington, once both an EMD and an EMT, left dispatching about 20 years ago after earning his education degree from the University of Utah. He taught elementary school for many years and now serves as a principal at a school in one of Utah’s fastest growing public school districts.

The 14 years Keddington spent in dispatch were at least a dozen more than he had anticipated, but those things happen when raising a family, working full time, and trying to find the perfect college major. The years there also coincided with the introduction of emergency medical protocol at the SLCFD communications center.

“There was a doctor,” Keddington recalled during a recent phone interview. “I think his name was Clawson, yes, Jeff Clawson. He had established this unique type of protocol system on flip charts and we’d flip to a chart depending on what the caller told us. I believe it was the first of its kind.”

In those days, dispatchers worked two to a shift, one answering the calls and the other dispatching the equipment. Classified ads published in a local newspaper during the same month as Jaime’s birth showed a starting wage of $4/hour for an entry-level dispatcher, which was well above the national minimum wage of $3.10/hour. Most ads for dispatchers required applicants to be able to type.

Dr. Clawson was the fire surgeon for the SLCFD and in 1980 he was one year into testing his protocol system at the communications center. By the time Keddington switched careers and left the SLCFD, the National Academy of Emergency Medical Dispatch® (NAEMD) had been established to develop and maintain the protocol now used in centers worldwide.

Keddington said he liked using the protocol system, having worked at the communications center both before and after its introduction.

“It was a good thing, especially for the new people,” he said. “It took the guess work out of what we were doing.”
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