Happy 5-Year Anniversary NAEMD!

A Standard of Care

*Robert L. Martin, Executive Director*

Emergency medical dispatch has come a long way in the past five years. By marking the NAEMD's 5-year anniversary, this newsletter is a very important issue for the Academy and for all Academy-Certified EMDs. In the Fall of 1988 the Academy was formed to provide a certification registry and international forum for discussing standards and issues relating to medical dispatch. In addition, the NAEMD was charged with helping standardize dispatch life support by maintaining the integrity of the MPDS protocols and of the associated EMD training curricula. Five years later, in 1993, the Academy has grown to encompass a currently certified dispatch registry of nearly 8,000 “standard of care” exists. I believe it does.

It is important to note that the NAEMD is not an “association” of dispatchers, it is a formal “Academy,” designed from its inception to mature as a nonprofit, academic standard-setting institution. It is one of several national EMS organizations dedicated to improving patient care and maximizing the efficiency of EMS systems. Today, dispatchers are no longer considered “clerks” or “receptionists” who merely intercept calls and send professional EMS responders, they are professional EMS first responders for every emergency call made into any dispatch center.

We do have a dispatch standard of care. Of course, this “standard” is still being defined and refined as EMD programs and publications continue to be promulgated by EMS agencies, medical control organizations (including the NAEMD), federal, state and local governments and even the general public. The pivotal importance of the medical dispatcher is increasingly apparent. We should all be very proud!

The process of professionalizing EMD did not occur overnight. The concerted efforts of many individuals and organizations had to coalesce so that a recognized “standard of care” could be established and accepted for medical dispatch. Five years ago, the year 1988 played a key role in this advancement. That year, in addition to the NAEMD’s formation, the American College of Emergency Physicians (ACEP) and the National Association of EMS Physicians (NAEMSP) both issued formal position statements affecting emergency medical dispatch.

On March 31st (1988), the Board of Directors of ACEP approved a paper entitled “Guidelines for Emergency Medical Services Systems.” That document was developed by the EMS Committee of ACEP, involving expert representatives from several national organizations, including: the American Ambulance Association, the International Association of Fire Chiefs, the National Association of EMS Physicians, the National Association of Emergency Medical Technicians, the National Association of State EMS Directors, and the National Council of State EMS Training Coordinators. Among other important statements, the ACEP document formally recognized dispatchers as an integral part of the overall EMS system and called for medical direction, structure and authority. It declared that “There must be a comprehensive communications plan with...established training and certification standards for EMS dispatchers” that “The agency will develop an ambulance placement plan that includes... level of response, ie, BLS versus ALS versus aeromedical” and that “The agency will assure the availability of educational programs within the system... [and make] continuing education available for all providers in the system with recertification as mandated.”

On June 12th (1988), the National Association of EMS Physicians issued their “Consensus Document on EMD,” later to be revised, expanded and published as a “Position Paper on Emergency Medical Dispatch.” This position paper boldly declared that “Training as EMDs is required for all dispatchers functioning in medical dispatch agencies” that “Certification and authorization by government agencies...must be required” and that “Pre-arrival instructions are a mandatory function of each EMD in a medical dispatch center.” These are strong statements, not easily met by viewing the EMD in a traditional “clerk” role.

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MPDS Q&A

Scott A. Hauert
Director of Curriculum

Thanks to everyone who has sent me their comments, suggestions, and inquiries. For this issue's column I've decided to discuss four important questions that have each been asked more than once.

Q. Our agency is using "dispatch feedback reports" to give the dispatchers input on what is discovered during QA case review. Our problem as EMDs is that all we hear about are the bad things and it is becoming discouraging. We know we have more things go right than wrong! How do other EMDs feel about their feedback?

A. Feedback evaluations, when handled correctly, should be received positively by the professional practitioner who is interested in improving their job performance. This requires that each review be fair and objective and that the advice, counsel or remediation is offered with positive intent, including alternative methods on how the EMD might handle similar cases in the future. If dispatchers consistently receive poor evaluation and are not afforded the benefit of positive and constructive feedback which incorporates solutions, they will predictably not respond well. If the only tools in the management "toolbox" are a mallet and screwdriver, everyone has the impression that they are always getting either hammered or screwed. If you are the one doing case review and providing feedback, please make sure your toolbox contains some polish and a chamois cloth. The fact remains that proper use of the MPDS requires evaluation of individual EMD compliance to verify the accuracy and effectiveness of protocol use. Feedback is an important tool. Without it we cannot learn from our experience, only suffer from it.

Q. If an EMD receives a call with multiple chief complaints, such as chest pain with breathing problems and abdominal discomfort, which card protocol should I use? Should we prioritize using the ABCs as a natural progression of complaint severity (i.e., airway, breathing, and circulation — in that order)?

A. We do not recommend using the ABCs to create a progression of chief complaint selection. A patient with chest and abdominal pain who has difficulty breathing should be handled on Protocol #10 (Chest Pain), coded a 10-C-2 (abnormal breathing), then post-dispatch instructions for monitoring respiratory status should be given from Protocol G (Ensure ABCs). With multiple chief complaints, the dispatcher should access the most serious complaint, however, situations do arise that could be accommodated by more than one card and a subjective intelligent decision must be reasonably made by the dispatcher. It is impossible to create a specific card protocol for each and every medical situation that will arise. The dispatcher receiving a questionable or changing "chief complaint" from the caller should remain on the card they initially selected and complete the questioning, unless another complaint is given that clearly represents a higher potential urgency level. Remember that instructions for a not alert patient, a patient who becomes unconscious during questioning, one who is bleeding, or one who requires airway control, can be handled simply by properly using Protocol G — Airway, Breathing, Circulation. In addition, please note that regardless of which Protocol you initially access as the chief complaint-driven secondary survey, the end result in response coding would be CHARLIE level: Abdominal pain would shunt to Chest Pain after Key Question #1, while either Chest Pain or Breathing Problems would handle as either 10-C-2 or 6-C-1 which are basically identical classifications.

Q. "Quit asking me these @%#$! questions and just send me an ambulance!" — This is a statement that the EMD is often confronted with. How should it be handled and why are they really saying it?

A. When an EMD is interrogating a caller and the caller interrupts with something like "Stop asking me these questions and just send the ambulance" the EMD can easily become discouraged. If we investigate the caller's motive for asking this question it is usually because they perceive that the questioning is intended to qualify the patient for EMS or that they may be faced with a never-ending questioning sequence that will significantly delay the ambulance. The caller usually does not understand that there may be someone else in the dispatch center who is sending the ambulance. It should be considered safe practice to allow EMDs to tell a caller that "My partner is dispatching the ambulance right now. I need to ask you these questions so I can tell you what to do (or how to help) until they get there." An EMD may also say that the ambulance is "has been sent" if this is in process. This can alleviate the "ambulance is not coming notion" often held by the caller which can motivate negative behavior. We are aware of no situation where a dispatch center incurred liability for telling a caller that the ambulance was being sent, provided the ambulance is indeed promptly sent.

Q. I get a lot of calls for unconscious diabetic and seizure patients. Should I go to Protocol #30 (Unconscious/Fainting) or the specific protocol for that chief complaint?

A. The unconscious person protocol is designed to be used when the patient is unconscious and you don't know why (unknown cause). If the caller says that the patient is unconscious because..." then always use the protocol that best matches the clearest reason for the unconscious condition. All unconscious patients can be monitored well by using Protocol G. The specific reason for the unconscious state (such as a seizure, diabetes, or trauma) may sometimes require additional or more specific post-dispatch instructions found on that protocol.
A Standard of Care, cont.

As the Academy has grown and developed, so has this EMD professionalization process continued to evolve. In 1990 the American Society for Testing and Materials (ASTM), under grants from the U.S. Department of Transportation, published their "Standard Practice for Emergency Medical Dispatch." This document defined an EMD as "a trained public safety telecommunicator with additional training and specific emergency medical knowledge essential for the efficient management of emergency medical communications." In 1992, the American Medical Association formally recognized the EMD as a "vital but often neglected part of the EMS system" and stated that "all communities should provide formal training in emergency medical dispatch and require the use of medical dispatch protocols, including prearrival instructions for airway control, foreign-body airway obstruction, and CPR by telephone."  

With these acknowledgments, trained and certified EMDs can finally take their rightful place alongside other professionally trained EMS responders. Finally, EMDs have been recognized as an important link in what the American Heart Association has termed the "Chain of Survival." Syndicated television programs such as Rescue 911 portray the EMD as a modern "hero" capable of providing immediate professional intervention in times of crisis. But, with this new public expectation also comes increased responsibility on the part of the dispatch agency and on the part of the NAEMD.

A recent article published in 9-1-1 Magazine reads that "widespread viewing of TV telecommunicators can up the ante when it comes to standards of care...if the public by virtue of their exposure on TV to 'the ways other people do it' comes to reasonably expect a certain level of service delivery - a standard of care - then you'd better be prepared to deliver service at that level. If you don't, the liability exposure to which you are subjecting yourself and your department is staggering."  

Today, in an effort to help provide a more formal dispatch review process, a stronger international EMD support network, and to encourage adherence to this newly defined "standard of care," the Academy's College of Fellows maintains the integrity of the MPDS protocols, of EMD certification curriculum, and all aspects of Dispatch Life Support (DLS). By following an academic process of reviewing and, where appropriate, approving proposed modifications and improvements, the dispatch protocols remain unified, standard and not subject to arbitrary, anecdotal modifications that may not be medically nor legally supportable.

Your support of the NAEMD, through certification, recertification and continuing education, is vital. Please join with us in celebrating the events of the past five years. There is now a unified and defined standard of care to follow and an academic organization to help us achieve that standard. We've come a long way. Let's be proud!  

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2. Ibid, p. 744.

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CONSIDER: Did Kipling write this about the dispatcher's 60-second dilemma?

"If you can fill the unforgiving minute with sixty seconds worth of distance run, yours is the earth and everything in it..."

—Rudyard Kipling

If you know of a certified EMD who did not receive this journal newsletter, please call us toll-free. Also remember to tell us if you move—WE WANT TO KNOW!
Continuing Dispatch Education

• Robert L. Martin, Exec. Dir.

Since installing the Academy’s new toll-free phone number, we are receiving significantly more calls regarding continuing dispatch education. According to current standard of care documents, the actual responsibility for maintaining a continuing medical education program for dispatchers falls upon the EMS dispatch centers. However, as continuing dispatch education, or CDE, is a key component in Academy recertification, the NAEMD can provide an information and support “clearing house” to assist an agency in initiating, enhancing and sustaining such a program.

First, I should make clear the particular Academy recertification requirements. Each individual EMD’s recertification is due the last day of the month, two years after the date shown on their NAEMD certificate. This date usually corresponds with the last day of an Academy-sponsored training course. The Academy issues pocket certification cards with each expiration date imprinted as a reminder. Those EMDs up for recertification should receive a notice with their newsletter a few months before this date. To qualify for Academy recertification, every two years an EMD must:

1. Complete the Academy’s “open-book” 30 question correspondence exam with a score of at least 80%,

2. Maintain current standard CPR certification or a DLS equivalent,

3. Verify completion of at least 24 hours of CDE (in addition to CPR) during the recertification period—an average of 1 hour/month, or 12 hours/year,

4. Submit a renewal fee of $45 with a completed recertification application. This fee covers dues, patch, newsletter, postage and testing. In refresher courses sponsored by the NAEMD, this fee is included in the tuition.

Usually, for an EMD actively working at a dispatch center, the CDE requirement is the only concern. This requirement is not meant to be difficult or troublesome. Because the scope of continuing education for dispatchers is much more broadly defined than continuing medical education requirements for paramedics or EMTs, participation in almost any supplementary EMS-related activity can qualify for completion of the CDE requirement. Of course, EMD-specific activities are always preferred, but most educational, organizational or quality assurance involvement that goes beyond the scope of normal work experience will qualify. In fact, on-duty work experience as a dispatcher or field responder qualifies for up to four credit hours in the “miscellaneous” category.

The Academy has outlined seven “CDE-approved categories” in which tracking individual hours is recommended. These categories are:

1. Workshops & seminars (16 hrs. max),
2. Local planning & management meetings (8 hrs. max),
3. Quality assurance & case review (8 hrs. max),
4. Audio-visuals (4 hrs. max),
5. Teaching the public (4 hrs. max),
6. MPDS protocol review (4 hrs. max), &
7. Misc.—incl. work experience (4 hrs. max).

There are maximum CDE-hour limits attached to each category to encourage some diversity. We do not want, for instance, the completion of a 40-hour EMT course to also complete the entire dispatch education requirement. However, since EMT training is EMS-related, 16 hours of the course could be counted under the “workshops and seminars” category, leaving 8 CDE hours that must still be completed in other areas, preferably in those areas that are more dispatch-specific. Some good examples include stress management and telephone skills courses, ambulance, hazmat or disaster drills and planning meetings, medical conditions or trauma incident scenarios and review. By specifying maximum hours in each category, 48 hours are potentially possible, but only half that amount—or 24 hours—is required. Where appropriate, a supervisor or instructor’s initials should be obtained to verify the CDE hours awarded. A certain license to interpret the extent of these categories is granted to those EMDs working for centers without an organized continuing education program. A well thought out agency-sponsored CDE program should be organized around the specific training and responsibilities of the EMD and should meet the following CDE program objectives:

1. Develop a better understanding of telecommunications & of the EMD’s specific roles & responsibilities,
2. Enhance on-line skills in PAs & in all emergency telephone procedures within the practice of EMD,
3. Improve skills in the use or application of all component parts of the MPDS, incl. interrogation & prioritization,
4. Seek opportunities for discussion, skill practice, & critique of skill performance.

The pursuit of CDE is an important component of maintaining the professionalism and integrity of emergency medical dispatch. It is also a key requirement for agency Accreditation as a “Center of Excellence.” The Academy has included in its Code of Ethics the statement that certified EMDs should “continually seek to maintain and improve their professional knowledge, skills and competence and should seek continuing education whenever available.”

I hope this discussion will be helpful to EMDs submitting their recertification forms and also assist each dispatch agency in developing their own CDE program.

National EMD Certification Courses:

NOVEMBER 1993
12-14 Patchogue, NY
15-17 Saskatoon, SK Canada
19-21 Bangor, ME
19-21 Dartmouth, NS Canada
29-1 Las Vegas, NV

DECEMBER 1993
1-3 Fort Worth, TX
15-17 Keyser, WV